Washington Medical Commission

UPDATE!

Vol. 15 Winter 2025

Message from the Chair

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

Clear Documentation and Effective Communication

Terry Murphy, MD

I wish to address an essential foundation of high-quality medical practice: clear documentation and effective communication. In regulating physicians, physician assistants and certified anesthesiologists, we are reminded time and again, how fundamental these practices are, not only for legal and compliance purposes, but also for quality patient care, transparency, and trust.

Why This Matters

When a patient seeks care, they entrust you with their health, well-being, and often their most vulnerable moments. The medical record comprised of your notes, orders, and documentation, becomes a vital thread in that care: a living record of decisions, observations, patient communications, and follow-up plans. Of equal importance is how you communicate with patients, families, and other providers. Poor or unclear documentation and communication can compromise care, lead to misunderstandings, increase risk of complaints or adverse events, and erode trust.

What We See — Common Pitfalls

In recent years, the Commission has noticed certain patterns in our review of cases. Frequently, we encounter records where clinical rationale is under-documented, follow-up plans are vague or absent, or communication between providers (especially during transitions of care) are incomplete. In other situations, patients or families report confusion about diagnoses, risks, or treatment plans because the information was not clearly or effectively conveyed. Often, these issues arise not because of willful neglect, but because of time pressure, high patient volume, or assumptions that "someone else will handle it."

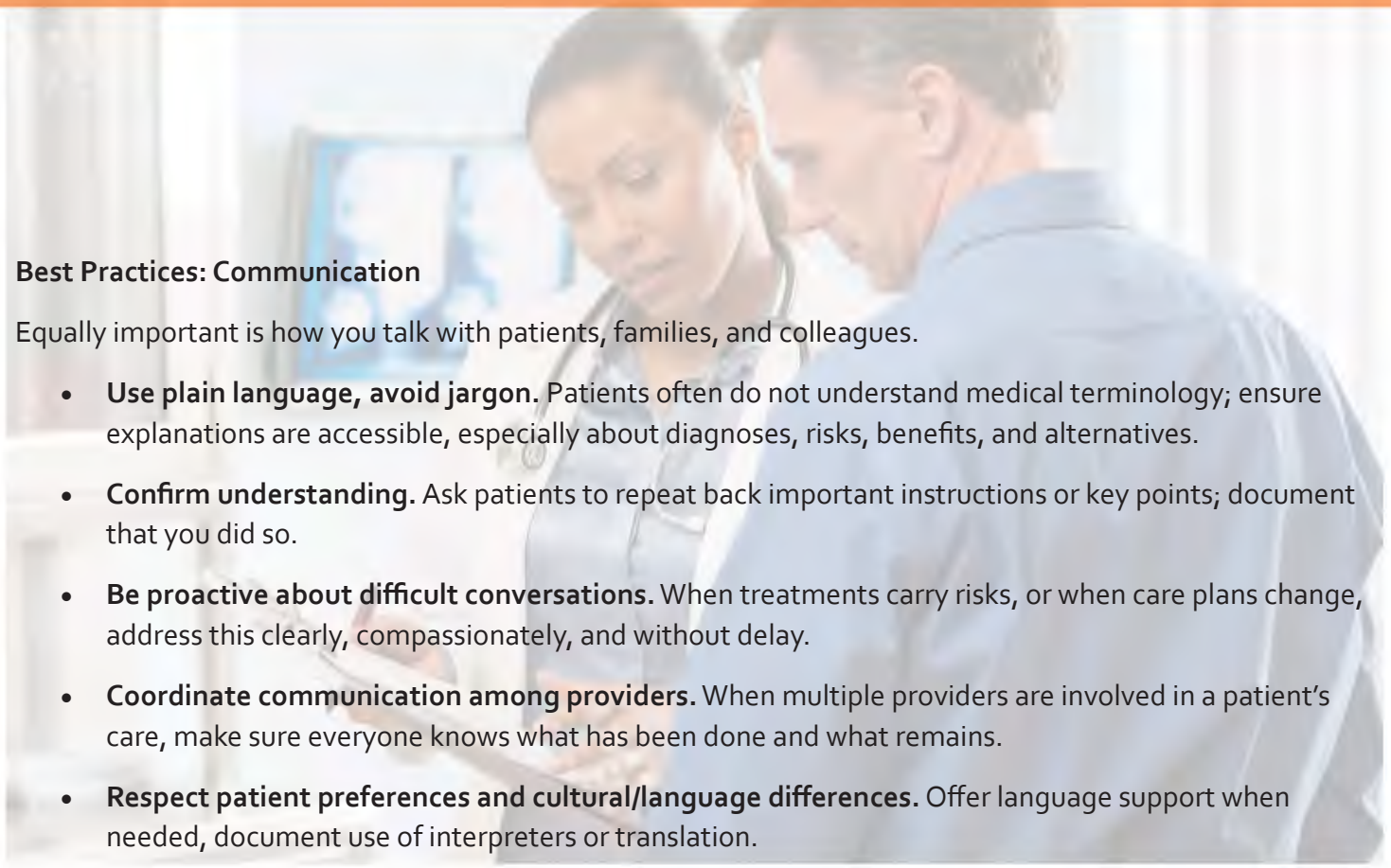
With Open Notes, patients often read their notes and if they see an exam listed that was not done, they interpret this as fraud and false documentation, and it undermines their trust. If they see old diagnoses or problem lists carried forward into your note, they see this as the provider being careless and inaccurate and falsifying the note. Patients do not understand that we use templates to help get through the mountain of documentation required and they don't see that as a valid excuse. Review your notes and remove anything that was not done or is not relevant to that specific encounter.

Best Practices - Documentation

To support safe, effective, and transparent care, we encourage you to:

- **Document clearly and contemporaneously.** Record findings, plans, and patient communications as soon as possible; avoid waiting until the end of the day or later.
- **Be specific.** Instead of vague statements like "patient advised," note exactly what was discussed, what the patient understood, and what follow-up was recommended.
- **Use consistent, standardized language.** This helps other providers quickly understand the record.
- **Ensure continuity across transitions of care.** When transferring care, ensure the receiving provider has access to complete, up-to-date documentation, including summaries of key data, recent labs or imaging, and plans.
- **Document follow-up plans.** Don't assume that the "patient will call if things worsen." Instead, specify next steps: when to return, who to call, what to monitor, and under what conditions to seek urgent care.

"While we sometimes see documentation or communication failures that lead to complaints, we also know that providers strive continually to improve. We are committed to supporting best practices, not punishing honest errors."



Best Practices: Communication

Equally important is how you talk with patients, families, and colleagues.

- **Use plain language, avoid jargon.** Patients often do not understand medical terminology; ensure explanations are accessible, especially about diagnoses, risks, benefits, and alternatives.
- **Confirm understanding.** Ask patients to repeat back important instructions or key points; document that you did so.
- **Be proactive about difficult conversations.** When treatments carry risks, or when care plans change, address this clearly, compassionately, and without delay.
- **Coordinate communication among providers.** When multiple providers are involved in a patient's care, make sure everyone knows what has been done and what remains.
- **Respect patient preferences and cultural/language differences.** Offer language support when needed, document use of interpreters or translation.

The Role of the Commission and How We Support You

Part of our responsibility is to ensure that care in Washington remains safe and professional. While we sometimes see documentation or communication failures that lead to complaints, we also know that providers strive continually to improve. We are committed to supporting best practices, not punishing honest errors.

A Shared Responsibility for Trust

Ultimately, good documentation and communication are not optional extras, they are essential to professionalism, patient safety, and the public's trust. I encourage each of you to reflect on your own practice: When was the last time you updated your documentation style? Could you make your communications clearer? Could follow-ups be more explicit?

Thank you for your dedication to high-quality care. By committing to these principles, we further strengthen the integrity of medicine in Washington for patients, for their families, and for our profession as a whole.

Executive Director Report

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

Retirement from Practice in the Context of Health Issues

Kyle Karinen, J.D., LL.M

As the calendar year winds to a close, I want to highlight a legal issue the Commission is working to address, but I also want to acknowledge Dr. Claire Trescott. In October, Dr. Trescott stepped down from the Commission. During her two terms with the Commission, she was heavily involved in the adoption of the revised opioid prescribing rules, was a stalwart member of multiple hearing panels and Case Management Team meetings, and reviewed hundreds of cases. A very heartfelt thanks, Claire. You will be missed, but you will not be forgotten.

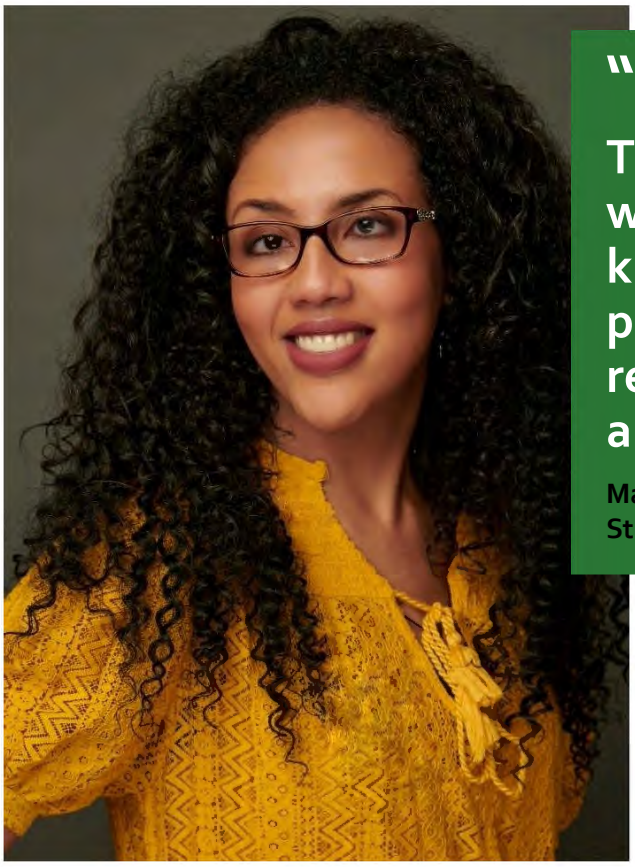
As mentioned above, there are a handful of issues the Commission keeps tabs on. I want to highlight one in particular here: retirement from practice in the context of health issues. It may seem counter-intuitive, but as the practice acts for physicians and physician assistants currently stand, there is no mechanism for licensees to relinquish their licenses. A licensee may choose to let their license expire, but as they do, they still retain the ability to reactivate that license. That ability – reactivation of an expired license – exists in perpetuity with few exceptions. One of those exceptions is when a licensee permanently surrenders their license to the Commission through a stipulated agreement under the Uniform Disciplinary Act. But again, there is no legal mechanism for physicians and physician assistants to simply relinquish their licenses permanently.

The Washington Physicians Health Program (WPHP) approached the Commission in 2024 regarding a path for licensees who are engaged with WPHP and WPHP has concluded that it cannot endorse a licensee to practice with reasonable skill and safety due to health issues. There is a statutory duty for WPHP to notify the Commission (and the other disciplinary authorities that fall under the contract between the Department of Health and WPHP) of its inability to endorse a licensee. In many cases, WPHP makes this notification due to a health issue that can be addressed with treatment, but there is a small subset of these instances where a health condition has permanently impacted a licensee's ability to practice safely. It is this last set of instances that represent one of the most difficult situations the Commission encounters. For example, please imagine a 70-year-old physician who has taken care of patients for 30 or 40 years with no issues, but who might be experiencing cognitive decline. They may have reached a point in their career where they simply cannot practice safely.

Typically, the notification begins a process where the Commission will open an investigation into the circumstances underlying WPHP's conclusion. That investigation process is done pursuant to the provisions of the Uniform Disciplinary Act and if there is a surrender, that notification is posted on the Department's Provider Credential Search and reported to the National Practitioner Data Bank. For that hypothetical physician I mentioned above, it might be terribly difficult to go through an investigation. On top of that, potentially having their own medical condition made a permanent – and public – part of their career when they simply want to be able to step away from a lifetime of taking care of patients and being remembered for that. It would simply be better for all involved if there was a pathway for physicians and physician assistants in this situation to notify the Commission that they wish to relinquish their licenses. That is not the case currently. The Commission acknowledges this difficult situation and the emotional toll it may take on those going through it but unfortunately there is no alternative legal mechanism.

During Dr. Trescott's two terms with the Commission, she was heavily involved in the adoption of the revised opioid prescribing rules, was a stalwart member of multiple hearing panels and Case Management Team meetings, and reviewed hundreds of cases.

Viral Labor Videos & Maternal Mortality



> "Their resonance stems from the way they brought visibility to known disparities, illustrated preventable harm, and reflected common experiences among Black women.

Mahlet Zeru, MPH
Strategy Manager

Recent viral videos depicting Black women being denied or delayed care while in active labor have sparked a national conversation about maternal health inequities[1]. Although the incidents occurred outside Washington State, they highlight patterns long documented across U.S. healthcare systems and offer meaningful lessons for providers here at home. These widely circulated clips, one involving a woman in Texas left in a wheelchair during active labor[2], and another in Indiana where a woman delivered in her car shortly after being discharged received millions of views in just days[3]. Their resonance stems from the way they brought visibility to known disparities[4], illustrated preventable harm[5], and reflected common experiences among Black women[6].

The power of these videos stems from the fact that they reflect the findings that research has supported for decades. The United States continues to have the highest maternal mortality rate among high-income nations, with Black women facing pregnancy-related death rates three to four times higher than white women.[7,8,9] They also experience severe maternal morbidity at disproportionately high rates, including hemorrhage, hypertensive crisis, infection, and cardiomyopathy.[10] These inequities persist even when comparing individuals of similar education, insurance status, and prenatal care use. Demonstrating that structural racism and differential treatment, not individual risk factors drive much of the disparity.[11,12] Seeing Black women in visible distress, dismissed or left waiting in these videos closely mirrors research showing that Black patients' pain is more likely to be underestimated or undertreated.[13]

The videos resonate because they showed preventable harm unfolding in real time. The CDC estimates that roughly 80 percent of pregnancy-related deaths in the U.S. are preventable.[14] Delayed symptom recognition[15], communication breakdowns[16], and inconsistent triage practices[17], failures that appear in national maternal mortality data, were clearly visible in these videos.

Washington State's own 2025 Maternal Mortality Review Panel (MMRP) reported 82 percent of pregnancy-related deaths were preventable in 2021-2022.[18] The 2025 MMRP found that most pregnancy-related deaths in the state remain preventable, particularly among Black, American Indian/Alaska Native, and Pacific Islander women.[19] The report identified delayed recognition of warning signs, missed opportunities for escalation, poor care coordination, and lack of culturally responsive care as recurring contributors to preventable deaths.[20] Behavioral health conditions, including substance use and suicide account for a significant proportion of pregnancy-associated deaths, and the MMRP emphasized that marginalized communities face greater barriers to postpartum follow-up and supportive services. The MMRP findings indicate that Washington state is susceptible to the same issues shown in the viral labor videos and recommendations must be implemented to reduce maternal mortality.

The public response to the videos was also intensified by how closely they matched the lived experiences of many Black women.[21] National surveys show that one in three Black women report discrimination in pregnancy or childbirth[22], and many describe feeling dismissed, disrespected, or excluded from decision-making.[23] The MMRP report similarly noted patient and family accounts of being unheard or having symptoms minimized, especially among families of racial and ethnic minorities. The viral videos validated these experiences and highlighted that such experiences are not isolated but systemic. [24,25]

Triage delays, a central theme in both viral cases, are another known contributor to poor outcomes[26]. Research shows that Black women wait significantly longer for clinical assessment, even when presenting with symptoms requiring urgent evaluation.[27] After adjusting for potential confounders, Black women waited 46 percent longer than White women for emergency evaluation of pregnancy-related concerns.[28] The MMRP report identified delayed triage and inconsistent response times as recurring issues contributing to preventable deaths in Washington State.

Given these parallels, the viral videos offer a painful reminder of the consequences of delayed or biased care but also provide a renewed opportunity to strengthen maternal care. Standardizing triage and admission with objective criteria, ensuring immediate evaluation of high-risk symptoms, and tracking time-to-triage metrics by race to identify bias are all evidence-based strategies to reduce maternal mortality.[29] Ongoing implicit bias training emphasizing cultural humility[30], structural competency, and communication skills have also been instrumental competencies for sustainable change[31]. The MMRP report also recommends strengthening continuity of care across pregnancy and the postpartum year, expanding culturally concordant support services such as doulas, and integrating behavioral health screening and treatment into perinatal care. Incorporating equity indicators such as severe maternal morbidity rates, postpartum follow-up, and care coordination into quality improvement dashboards can help systems detect disparities early and intervene effectively.[32]

Endnotes are available on page 16

Take a moment before you submit a new or renewal application to view the dedicated webpage on using HELMS – the DOH online licensing platform

WPHP Report

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

WPHP's Education & Outreach in Our Medical Community

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

Vanessa Bloy, MSS
Communications Manager, Washington Physicians Health Program

An essential component of the Washington Physicians Health Program's (WPHP) mission is to provide education and outreach to the medical community on physician health and impairment. We are dedicated to providing physicians with accurate, evidence-based data that empowers them to recognize concerns, seek appropriate support, and make informed decisions—whether for themselves or a colleague in need. As an independent, physician-led, nonprofit organization, we strive to further strengthen awareness about WPHP and vital our role in supporting Washington's medical professionals.

Through our statewide outreach efforts, we work to advance physician health and well-being and deepen understanding of the resources available through our program. To further this goal, we recently launched two new educational tools designed to help health professionals better understand about our organization and the services we provide.

New WPHP Video

We are pleased to share our first introductory video which offers an overview of WPHP's mission, outcomes, and the transformative impact our work has across the medical community. We invite you to watch the video which is available on our website.

WPHP Process Diagram

To enhance understanding of our program and the services WPHP provides, we designed an interactive diagram. It outlines WPHP's process and the paths that a health professional may embark on. WPHP offers early intervention, assessment, treatment referral, and post-treatment health support for medical professionals who may not be able to practice safely due to an impairing or potentially impairing health condition. The diagram offers a step-by-step look at what happens when a health professional contacts or is referred to WPHP.

WPHP Outreach

WPHP provides educational presentations to medical communities across Washington, highlighting our program, services, and a wide range of relevant health-related topics. Last year, we delivered 50 educational presentations reaching 2,899 health professionals.

In addition, WPHP conducted outreach meetings and presented at conferences to demonstrate the life-saving impact of Physician Health Programs (PHPs) and their confidential support services for health conditions. Presentations also explored how PHPs can enhance health workforce safety and sustainability.

Key Outreach Themes Include:

- Early intervention & prevention: Addressing health concerns such as mental health, substance use, and burnout, early on before patient safety may be compromised.
- Well-being and resilience: Promoting safe practice, physician wellness, and workforce sustainability.
- Confidentiality and safe referral: Educating health professionals on how WPHP provides confidential and therapeutic support as an alternative to disciplinary action.

WPHP serves dentists, veterinarians, PAs, as well as students and residents of these professions. Through outreach, we connect with:

- Learners (medical students and residents) to raise awareness early about impairment risks, wellness, and available support.
- Practicing clinicians and healthcare organizations to promote health and well-being, reduce stigma, and encourage early help-seeking.
- Institutional stakeholders (university training programs, licensing boards, hospitals, healthcare organizations, associations, and commissions) to integrate system-wide supports, clarify referral pathways, and embed education about physician health and safe practice.

Newsletters, Blogs & Social Media

WPHP publishes a quarterly Physician Health Focus newsletter and shares monthly blogs featuring news and updates on various healthcare topics. Follow WPHP on LinkedIn and Facebook for posts on healthcare matters, upcoming presentations, and resources for our medical community.

WPHP in the News

WPHP regularly contributes expertise and data to research articles, medical journals, healthcare newsletters, podcasts, television programs, and publications covering medical topics. Explore featured coverage of WPHP.

WPHP Advocacy

WPHP continues to make significant strides in advocating for license and credentialing reforms and addressing systemic barriers to mental health and well-being. We partner with local and national organizations on ways to reduce stigma and bias, raise early awareness about impairment, and provide resources. Just this month WPHP was able to work collaboratively with the Washington State Credentialing Standardization Group to reform the Washington Practitioner Application (WPA). As the result of WPHP's advocacy, the most widely used credentialing application in Washington will now align with national credentialing best practices to inquire only about current impairment and not past diagnoses or treatment.

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

" WPHP offers early intervention, assessment, treatment referral, and post-treatment health support for medical professionals who may not be able to practice safely due to an impairing or potentially impairing health condition. The diagram offers a step-by-step look at what happens when a health professional contacts or is referred to WPHP.

Legal Actions

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

August 1, 2025 – October 31, 2025

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

Practitioner Credential and County	Order Type	Date	Cause of Action	WMC Action
Formal Actions				
Arogundade, Kareematulai, MD MD.MD.60629787 Snohomish County	Default Order	10/9/25	Failure to comply with Commission order	Indefinite suspension.
Babu, Joseph, MD MD.MD.61431583 Out of state	Default Order	10/09/25	Restriction of license in Arizona.	Indefinite suspension.
Barbosa, Joilo C., MD MD.MD.00043302 Out of state	Default Order	10/8/25	Surrender of license in Arizona	Indefinite suspension.
Bunin, Alan, MD MD.MD.00010954 King County	Default Order	10/3/25	Incompetence; failure to cooperate with an investigation; failure to comply with a Commission order.	Indefinite suspension.
Hart, Robert A., MD MD.MD.60675896 King County	Waiver Order	9/15/25	Sexual misconduct with a patient.	Indefinite suspension.
Hill, Josiah D., MD MD.MD.61028088 Out of state	Agreed Order	9/10/25	Criminal convictions for fourth degree assault of patients.	Revocation.
Jackson, Ricky L, MD MD.MD.00019032 Clark County	Default Order	9/8/25	Inadequate supervision of PA; negligent care to patients seeking prevention or treatment for COVID-19 infections.	Restricted from entering into collaboration agreements with PAs; restricted from prescribing ivermectin for non-FDA-approved indications; must review UpToDate website for current guidelines on prevention, treatment, and management of COVID-19; CME on prevention, treatment, and management of COVID-19; ethics course; record-keeping course; paper; clinical monitoring program; personal appearances; fine. May petition to terminate in two years.

Kane, Sean, MD MD.MD.61108510 Whatcom County	Order of Summary Suspension	9/22/25	Alleged inability to practice with reasonable skill and safety due to a health condition.	Indefinite suspension.
Krause, David E., MD MD.MD.61654643 Out of state	Order of summary suspension	10/28/25	Alleged misrepresentation on application; prescribing for family members; self-prescribing of a controlled substance; failure to cooperate with an investigation.	Indefinite suspension.
Mulholland, Mark E., MD MD.MD.00038090 Benton County	Interim Stipulated Order Restricting Practice	9/17/25	Alleged negligence, sexual contact with patients, abuse of patients.	Restricted from practicing medicine with patients assigned female at birth or who identify as female, including in a consulting role with no patient contact.
Niazi, Asad K., MD MD.MD.61574280 Out of state	Order of summary suspension	8/27/25	Alleged denial of license application in Alaska; reprimand in California; failure to respond to investigation in Alaska.	Indefinite suspension.
Spolar, Trenton J., MD MD.MD.00011446 Clark County	Agreed Order	10/2/25	Failure to provide proof of CME after attesting in license renewal application that he met CME requirements and would provide them upon request.	Indefinite suspension.
Informal Actions				
Blair, James C. III, PA PA.PA10003105 Jefferson County	STID	10/3/25	Alleged current misuse of alcohol.	Contact WPHP to discuss assessment and treatment and follow all recommendations; CME in ethics; paper; personal appearances; costs. May petition to terminate in three years.
Killian, Robert K., MD MD.MD.00033951 King County	STID	8/21/25	Alleged sending of email to patient's work email address containing sensitive information, being asked by the patient not to do that, and then sending another email to the patient's work email address containing sensitive information.	Complete Enhanced Patient Communication seminar; CME in clinician-patient communication; paper; personal appearances; costs. May petition to terminate in one year.
Kim, Doug S., MD MD.MD.00027275 King County	STID	8/21/25	Alleged delays in documenting and inadequate documentation of prescriptions for opioid medication in patients' charts.	Agreement not to prescribe Schedule II medications for chronic pain patients; practice monitor; CME in opioid use disorders, acute and chronic pain management, and use of Schedule II narcotic medications; paper; register with PMP; compliance audits; personal appearances; costs. May not petition to terminate.

Morgan, Lavena M., MD MD.MD.61090693 Out of state	STID	10/2/25	Voluntary limitation in Oregon on performing laparoscopic surgeries.	Practice limitation: may not perform laparoscopic surgeries without presence of qualified gynecological or general surgeon; after completing ten procedures, may request termination of the practice limitation; personal appearances; costs. May petition to terminate when all conditions met.
Osmani, Saba F., MD MD.MD.61535491 Out of state	STID	8/21/25	Consent Order in Illinois with reprimand, CME in ethics, and fine.	Comply with Illinois consent order; costs. May petition to terminate upon completion of Illinois consent order.
Roy, Priscillia, MD MD.MD.61402925 Out of state	STID	8/21/25	Surrender of license in California.	Voluntary surrender of license.
Urbon, Richard L., MD MD.MD.00046758 King County	STID	8/21/25	Alleged negligent increase in dosage of IV morphine to hospitalized patient.	CME in pain management and safer prescribing of opiates; CME in pain management in the in-patient setting and pharmacology of IV opiates versus oral opiates; CME in patient communication and shared decision making; paper; personal appearances; costs. May petition to terminate in three years.
Vega, Fernando D., MD MD.MD.00018929 King County	STID	8/21/25	Alleged failure to consider a diagnosis of cancer in a patient with significant weight loss; providing guided psychedelic therapy using MDMA, a Schedule I medication, to the patient; negligent pelvic exam of second patient.	Restriction from treating patients with MDMA, psilocybin, or any Schedule I psychedelic or hallucinogenic substance; paper on ethics and risks and side effects of treating patients with Schedule I psychedelic substances; CME in diagnosing causes of unintentional weight loss in older adults, communication; trauma-informed care; and ethics; personal appearances; costs. May petition to terminate in two years.

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.
Order on Non-Compliance: An order issued after a health law judge has found a licensee has failed to comply with a Commission order.
Order of Reinstatement-An order reinstating a suspended license. It usually contains restrictions and conditions.
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.
Stipulation to Informal Disposition (STID): a document detailing allegations, but with no findings or admissions, and containing an agreement by the licensee to comply with certain terms and conditions to protect the public.

Rulemaking Efforts

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

Amelia Boyd
Program Manager

In Progress

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

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

Between July 2024 and January 2025, the WMC held three workshops, collaborating with the public, associations, and other interested parties to develop the draft language. At the final workshop held on January 27, 2025, the panel approved the draft language for presentation to the Commission at its March 14, 2025, Business Meeting. During that meeting, the Commissioners authorized moving forward with the next step in the rulemaking process, the CR-102, or Proposed Rules. The CR-102 was filed June 30, 2025, under WSR #25-14-080. On August 22, 2025, a hearing was held, and based on the testimony presented, the Commissioners voted to return to the CR-101 phase of rulemaking. A workshop was held on October 20, 2025, where the draft language was revised to include the testimony presented at the first hearing. On November 21, the Commissioners approved initiating a new CR-102 and rescinded the CR-102 filed under WSR #25-14-080. The second rules hearing is tentatively scheduled for March 13, 2026.

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 are ongoing. Please visit our Rules in Progress page for the current schedule.

Chapter 246-919 WAC, Allopathic Physicians (MD)

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

Collaborative Drug Therapy Agreements

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

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

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

Regulating the use of CDTAs would place the WMC in an active patient safety role. Rulemaking would provide clarity around this issue to help avoid potential discipline and increase patient safety. The new sections being considered will potentially benefit the public's health by ensuring participating providers are informed and regulated by current national industry and best practice standards.

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

Upcoming Rulemaking

Standard rulemaking: WAC 246-921-125(3), Anesthesiologist Assistants

Under WAC 246-921-125, pertaining to anesthesiologist assistants, subsection (3) reads: "Each anesthesiologist assistant shall have four years to meet the continuing medical education requirements … The review period begins at the **second** renewal after initial licensure or second renewal after reactivation of an expired license."

For physician assistants, the comparable rule, WAC 246-918-171 subsection (3) reads: "Each physician assistant will have two years to meet the continuing medical education requirements … The review period begins on the **first** birthday after receiving the initial license."

As a result of a technical error, there is an inconsistency between the two professions regulated by the WMC. Amending WAC 246-921-125 to replace "second renewal" with "first renewal" would promote consistency across professions, as both rules govern continuing education cycles and renewal review periods for advanced practice professionals under the Commission's oversight. Aligning the language would ensure fairness, clarity, and a simplified administrative process by reducing confusion for licensees who might otherwise calculate their eligibility differently. It would also better reflect the intended timing of continuing education review and support licensee understanding and compliance by clearly defining when the four-year review period begins.

On November 21, 2025, the Commissioners approved initiating rulemaking on this subject. The CR-101 is in process and workshops will be scheduled in the coming months. Please visit our Rules in Progress page for the schedule when it's available.

More Information

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

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

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

2026 Notice of Recruitment

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

The Washington Medical Commission (WMC) is currently accepting applications to fill upcoming vacancies. The WMC helps make sure physicians and physician assistants are competent and provide quality medical care.

We are looking for people willing to study the issues and make decisions in the best interest of the public. Our member selection reflects the diversity of the profession and provides representation throughout the state. On July 1, 2026, the WMC will have openings for:

- One physician representing Congressional District 3
- One physician representing Congressional District 5
- One physician representing Congressional District 9
- One Physician-at-Large
- One Physician Assistant
- Two Public Members

To determine what congressional district you live in, please visit the legislature website and enter your zip code.

The WMC is made up of 21 governor-appointed members who meet 6-7 times per year. In addition to these meetings, they regularly review multiple disciplinary cases, and additional meetings or hearings are frequently required. Additional information regarding commission membership can be found here. Please take the time to review the valuable information on commission membership available at the above website as well as this informational video on our YouTube channel that outlines the roles and responsibilities of Commissioners.

If you are interested in applying, please do so on the Governor's site. Applications, along with a current CV, must be received by **March 31, 2026.**

If you have any questions about serving on the WMC, please contact Amelia Boyd, Program Manager, by email at amelia.boyd@wmc.wa.gov, or mobile (360) 918-6336.

We are also seeking MDs with specialties in the following areas to serve as Pro Tempore (Pro Tem) Commissioners:

- General Surgery
- Neurosurgery/Neurology
- Orthopedic Surgery
- Ophthalmology
- Psychiatry
- Radiology
- Urology

Pro Tems have the same rights and responsibilities as Commissioners appointed by the Governor; except they cannot vote on business matters. Their term is limited to four consecutive one-year terms, and they are appointed by the WMC's Executive Director rather than the Governor.

If you are interested in serving as a Pro Tem, please contact Ms. Boyd to find out more about this opportunity.

Members

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

Medical Commission Members

Terry Murphy, MD - Chair
Ed Lopez, PA-C - Chair Elect
Elisha Mvundura, MD - Officer-at-Large

Michael Bailey
Christine Blake, CPMSM
Toni L. Borlas
Daniel Cabrera, MD
Po-Shen Chang, MD
Jimmy Chung, MD
Diana Currie, MD
Anjali D'Souza, MD
Karen Domino, MD
Arlene Dorrough, PA-C
Harlan Gallinger, MD
April Jaeger, MD
Jamie Koop
Sarah Lyle, MD
Robert Pullen
Scott Rodgers, JD
Richard Wohns, MD

Update! Editorial Board

Diana Currie, MD
Jimmy Chung, MD
Micah Matthews
Richard Wohns, MD
Jimi Bush, Managing Editor

WMC Mission

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

WMC Vision

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

EndNotes

1 Viral Videos of Women in Labor Being Denied Care Renews Conversation Around Black Maternal Health Care | Chicago News | WTTW

2 https://www.youtube.com/watch?v=1yJcIqj4OYk

3 CNN speaks to Indiana mom who gave birth on the side of road after hospital discharged her

4 Montalmant, K. E., & Ettinger, A. K. (2024). The Racial Disparities in Maternal Mortality and Impact of Structural Racism and Implicit Racial Bias on Pregnant Black Women: A Review of the Literature. *Journal of racial and ethnic health disparities*, *11*(6), 3658–3677. https://doi.org/10.1007/s40615-023-01816-x

5 Chen, Y., Shiels, M. S., Uribe-Leitz, T., Molina, R. L., Lawrence, W. R., Freedman, N. D., & Abnet, C. C. (2025). Pregnancy-Related Deaths in the US, 2018-2022. *JAMA network open*, *8*(4), e254325. https://doi.org/10.1001/jamanetworkopen.2025.4325

6 One in 5 Women Reported Mistreatment While Receiving Maternity Care | CDC Online Newsroom | CDC

7 Petersen, E. E., Davis, N. L., Goodman, D., Cox, S., Syverson, C., Seed, K., Shapiro-Mendoza, C., Callaghan, W. M., & Barfield, W. (2019). Racial/Ethnic Disparities in Pregnancy-Related Deaths - United States, 2007-2016. *MMWR. Morbidity and mortality weekly report*, *68*(35), 762–765. https://doi.org/10.15585/mmwr.mm6835a3

8 U.S. Maternal Mortality Crisis Comparison | Commonwealth Fund

9 Howell E. A. (2018). Reducing Disparities in Severe Maternal Morbidity and Mortality. *Clinical obstetrics and gynecology*, *61*(2), 387–399. https://doi.org/10.1097/GRF.0000000000000349

10 Petersen EE, Davis NL, Goodman D, et al. Racial/Ethnic Disparities in Pregnancy-Related Deaths — United States, 2007–2016. MMWR Morb Mortal Wkly Rep 2019;68:762–765. DOI: http://dx.doi.org/10.15585/mmwr.mm6835a3.

11 Hailu, E. M., Maddali, S. R., Snowden, J. M., Carmichael, S. L., & Mujahid, M. S. (2022). Structural racism and adverse maternal health outcomes: A systematic review. *Health & place*, *78*, 102923. https://doi.org/10.1016/j.healthplace.2022.102923

12 Harper, M. A., Espeland, M. A., Dugan, E., Meyer, R., Lane, K., & Williams, S. (2004). Racial disparity in pregnancy-related mortality following a live birth outcome. *Annals of epidemiology*, *14*(4), 274–279. https://doi.org/10.1016/S1047-2797(03)00128-5

13 Hoffman, K. M., Trawalter, S., Axt, J. R., & Oliver, M. N. (2016). Racial bias in pain assessment and treatment recommendations, and false beliefs about biological differences between blacks and whites. Proceedings of the National Academy of Sciences of the United States of America, 113(16), 4296–4301. https://doi.org/10.1073/pnas.1516047113

14 https://www.cdc.gov/maternal-mortality/preventing-pregnancy-related-deaths/index.html#:~:text=More%20than%2080%25%20of%20pregnancy,%2C%20and%2For%20community%20factors.

15 Krenitsky, N. M., Perez-Urbano, I., & Goffman, D. (2024). Diagnostic Errors in Obstetric Morbidity and Mortality: Methods for and Challenges in Seeking Diagnostic Excellence. *Journal of clinical medicine*, *13*(14), 4245. https://doi.org/10.3390/jcm13144245

16 Clark, R. R. S., Klaiman, T., Sliwinski, K., Hamm, R. F., & Flores, E. (2024). Using incident reports to diagnose communication challenges for precision intervention in learning health systems: A methods paper. *Learning health systems*, *8*(Suppl 1), e10425. https://doi.org/10.1002/lrh2.10425

17 ReportfromNineMMRCs.pdf

18 Washington State Department of Health. (2025). *Maternal Mortality Review Panel: 2025 Report*. Washington State Department of Health, Office of Family and Community Health Improvement. https://doh.wa.gov/public-health-provider-resources/public-health-system-resources-and-services/maternal-mortality-review-panel

19 Washington State Department of Health. (2025). *Maternal Mortality Review Panel: 2025 Report*. Washington State Department of Health, Office of Family and Community Health Improvement. https://doh.wa.gov/public-health-provider-resources/public-health-system-resources-and-services/maternal-mortality-review-panel

20 Washington State Department of Health. (2025). Maternal Mortality Review Panel: 2025 Report. Washington State Department of Health, Office of Family and Community Health Improvement. https://doh.wa.gov/public-health-provider-resources/public-health-system-resources-and-services/maternal-mortality-review-panel

21 Lister, R. L., Drake, W., Scott, B. H., & Graves, C. (2019). Black Maternal Mortality-The Elephant in the Room. World journal of gynecology & womens health, 3(1), 10.33552/wjgwh.2019.03.000555. https://doi.org/10.33552/wjgwh.2019.03.000555

22 Giurgescu, C., McFarlin, B. L., Lomax, J., Craddock, C., & Albrecht, A. (2011). Racial discrimination and the black-white gap in adverse birth outcomes: a review. Journal of midwifery & women's health, 56(4), 362–370. https://doi.org/10.1111/j.1542-2011.2011.00034.x

23 Prater, C., Cohen, L., Chau, E., Carter, E. B., Kuebee, B., Tepe, M., & Keegan, M. (2023). Perceived Discrimination During Prenatal Care at a Community Health Center. Journal of racial and ethnic health disparities, 10(3), 1304–1309. https://doi.org/10.1007/s40615-022-01315-5

24 https://aawellnessproject.org/silent-danger-what-this-viral-video-shows-about-er-bias-and-black-maternal-mortality/

25 https://www.youtube.com/watch?v=MLcihoIXUZ8

EndNotes

26 Deichen Hansen, M. E., Goldfarb, S. S., Mercouffer, A., Dark, T., Lateef, H., & Harman, J. S. (2022). Racial inequities in emergency department wait times for pregnancy-related concerns. Women's health (London, England), 18, 17455057221129388. https://doi.org/10.1177/17455057221129388

27 Deichen Hansen, M. E., Goldfarb, S. S., Mercouffer, A., Dark, T., Lateef, H., & Harman, J. S. (2022). Racial inequities in emergency department wait times for pregnancy-related concerns. *Women's health (London, England)*, *18*, 17455057221129388. https://doi.org/10.1177/17455057221129388

28 Deichen Hansen, M. E., Goldfarb, S. S., Mercouffer, A., Dark, T., Lateef, H., & Harman, J. S. (2022). Racial inequities in emergency department wait times for pregnancy-related concerns. *Women's health (London, England)*, *18*, 17455057221129388. https://doi.org/10.1177/17455057221129388

29 Report From Nine Maternal Mortality Review Committees https://www.cdcfoundation.org/sites/default/files/files/ReportfromNineMMRCs.pdf

30 Lekas, H. M., Pahl, K., & Fuller Lewis, C. (2020). Rethinking Cultural Competence: Shifting to Cultural Humility. *Health services insights*, *13*, 1178632920970580. https://doi.org/10.1177/1178632920970580

31 Sabin, J., Guenther, G., Ornelas, I. J., Patterson, D. G., Andrilla, C. H. A., Morales, L., Gurjal, K., & Frogner, B. K. (2022). Brief online implicit bias education increases bias awareness among clinical teaching faculty. *Medical education online*, *27*(1), 2025307. https://doi.org/10.1080/10872981.2021.2025307

32 Washington State Department of Health. (2025). *Maternal Mortality Review Panel: 2025 Report*. Washington State Department of Health, Office of Family and Community Health Improvement. https://doh.wa.gov/public-health-provider-resources/public-health-system-resources-and-services/maternal-mortality-review-panel