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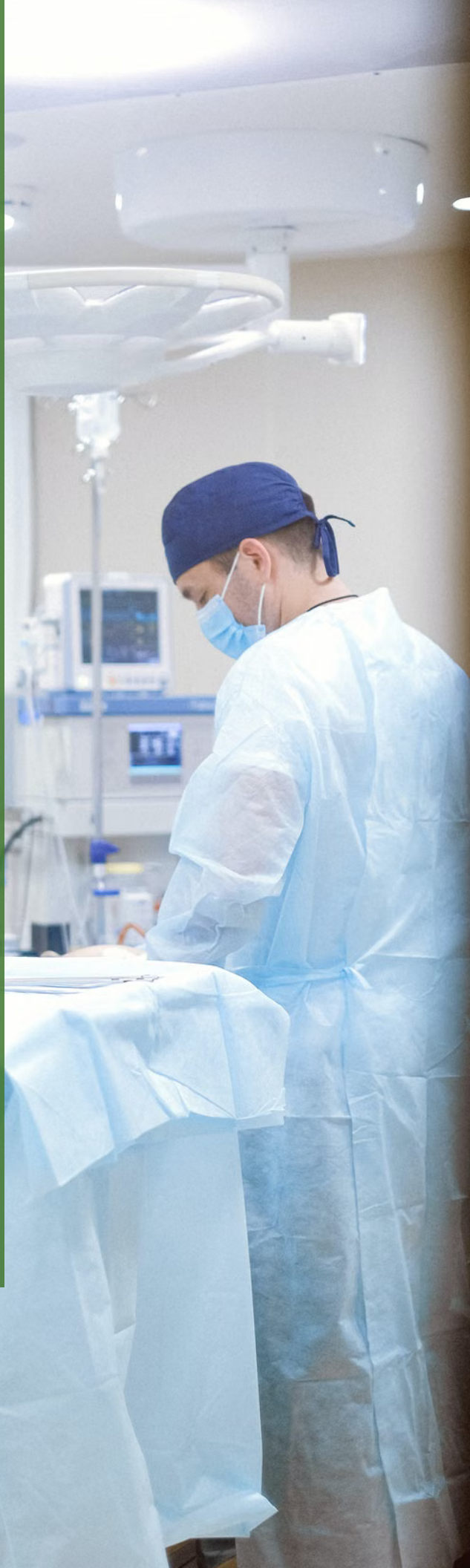
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WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

Oversight Challenges of Medical Spas: What Washington Physicians Need to Know

Terry Murphy, MD

Medical spas have become an increasingly visible part of the healthcare and wellness landscape. Services that were once primarily offered in traditional medical settings, such as cosmetic injections, laser treatments, body contouring, prescription-device procedures, and other aesthetic interventions, are now routinely marketed in environments that look and operate more like retail businesses than conventional medical practices.

For patients, the distinction may be difficult to recognize. For physicians, it is critical. In Washington, medical spa services can constitute the practice of medicine regardless of where they are delivered. We are seeing medical spa services being offered in medical clinics, wellness clinics, mobile clinics, and other settings. The legal requirements depend in part on the service being provided, the professional performing it (scope-of-practice) and supervision requirements.

For physicians who serve as medical directors, owners, supervisors, or treating providers in these settings, the central challenge is understanding where business responsibility ends and professional responsibility begins.

The Medical Director Is More Than a Name on the Door

One of the most significant misconceptions surrounding medical spas is that a physician can serve as a nominal medical director while day-to-day clinical decisions are effectively made by others. Washington's regulatory framework does not support that approach.

The Washington Medical Commission (WMC) has specifically identified medical directors' responsibilities in its guidance and rules. A medical director is responsible for ensuring that individuals working within the facility practice within their legal scope of practice. Failure to adequately supervise staff when patient health or safety is at risk is a form of unprofessional conduct.

This means physicians should carefully consider what they agree to when accepting a medical director position. Signing standing orders, protocols, or business documents does not eliminate the physician's responsibility to understand how care is actually being delivered.

A physician should be able to answer basic questions about the practice:

- Who evaluates the patient before treatment?
- Who determines whether a patient is an appropriate candidate?
- Who establishes the diagnosis, when applicable?
- Who determines which treatment is medically appropriate?
- Who performs the procedure?
- What training does the individual performing the procedure have?
- What happens when a complication occurs?
- Who is immediately available to manage that complication?
- How are adverse events documented and reviewed?
- Who has authority to stop a procedure or suspend a treatment protocol?

If you cannot answer these questions, the arrangement deserves closer examination.

The physician's obligation remains centered on patient safety, appropriate clinical judgment, informed consent, and competent care. The fact that a patient has purchased a service does not make that service medically appropriate.

Delegation Does Not Mean Abdication

Washington has established specific requirements for physicians who delegate nonsurgical medical cosmetic procedures. Certain cosmetic procedures may be delegated to physician assistants, registered nurses, or licensed practical nurses when the regulatory requirements are satisfied. Those requirements include appropriate training, written office protocols, patient-selection criteria, pre- and post-procedure care, and plans for managing complications and emergencies. The distinction is important: delegation transfers the performance of an authorized task; it does not transfer the physician's responsibility to appropriately supervise the practice. For physicians working with medical spas, these requirements should be viewed as the beginning, not the entirety of responsible clinical oversight.

The Business Model Can Create Additional Risk

Medical spas occupy an unusual space between healthcare and consumer commerce. Treatments are frequently advertised through social media, promotions, memberships, discounts, referral programs, and before-and-after photographs. That commercial environment can create pressures that are uncommon in traditional clinical practice.

A patient may arrive having already purchased a treatment package. Staff may have financial incentives tied to the number of procedures performed. Marketing may promote a particular product or procedure before a patient has received an individualized clinical assessment. These circumstances can create an important question for physicians: Is the clinical decision being driven by the patient's medical needs, or by the business model?

The physician's obligation remains centered on patient safety, appropriate clinical judgment, informed consent, and competent care. The fact that a patient has purchased a service does not make that service medically appropriate.

Scope of Practice Becomes Increasingly Important

Medical spas may employ a range of licensed and unlicensed personnel. Each professional brings a different scope of practice, and those scopes cannot simply be expanded through a business's internal policies. Allowing an individual to exceed their legal scope of practice can result in disciplinary action involving not only the person performing the procedure, but potentially the medical director and supervising physician as well. This creates a particular challenge when practices use titles such as "aesthetic provider," "injector," or "medical aesthetician." A job title does not establish legal authority to perform a procedure.

Physicians should therefore evaluate the actual credentials, education, training, demonstrated competency, and legal scope of every individual performing medical procedures under their oversight.

A sound medical spa oversight program should address:

1. Before treatment: appropriate patient evaluation, medical history, contraindications, informed consent, and treatment planning.
2. During treatment: appropriate technique, infection prevention, medication and device safety, and adherence to established protocols.
3. After treatment: discharge instructions, follow-up, recognition of complications, escalation procedures, and access to appropriate medical care.
4. When something goes wrong: a clearly understood emergency response plan, documentation, communication with the patient, and appropriate referral or transfer of care.

The ability to respond to complications should be considered when determining whether you are comfortable supervising a particular procedure or practice.

Devices and Products Require Particular Attention

Another challenge is the rapid evolution of aesthetic technology. New devices, compounded products, injectables, and treatment approaches can enter the marketplace faster than clinicians can become familiar with their risks and regulatory status. Physicians should not assume that a device or product is appropriate simply because it is being widely marketed or used elsewhere. The WMC has separate rules addressing lasers and similar prescription devices, as well as nonsurgical medical cosmetic procedures.

Before agreeing to oversee a procedure, physicians should understand:

- Whether the device is a prescription device;
- Whether the intended use is within the device's FDA-cleared or approved indications;
- Whether the medication or substance is FDA-approved and for what use;
- Who is legally authorized to administer it;
- What training is required;
- What complications can occur; and
- What level of physician supervision is required.

The Physician Should Know the Practice They Are Supervising

Ultimately, effective oversight requires more than periodic availability by telephone. Physicians considering a medical director or supervisory role should conduct meaningful due diligence before accepting the position. That may include reviewing clinical protocols, personnel credentials, training records, patient-selection procedures, informed-consent materials, emergency plans, documentation practices, equipment, medications, and quality-assurance processes. It is also important to understand the business arrangement itself. Physicians should know who owns the practice, who employs the clinical staff, who controls the clinical environment, and who has authority to make clinical decisions.

Operating a medical spa involves complex considerations related to ownership, business structure, scope of practice, supervision, and the specific services being provided. The WMC recommends obtaining appropriate legal counsel because the applicable requirements can be extensive.

A Changing Regulatory Environment

Washington's approach to medical spas continues to evolve. The Department of Health has convened an interprofessional Medical Spa and Esthetic Services Work Group to identify existing requirements, clarify regulations, address business considerations, and support safe delivery of medical esthetic services. This ongoing attention reflects a broader reality: the delivery of healthcare is changing, and regulation must continue to address new models of care without losing sight of the fundamental purpose of professional regulation, protecting patients.

A Final Consideration for Washington Physicians

Medical spas can provide legitimate, appropriate, and valuable services to patients. The issue is not whether aesthetic medicine belongs in these settings. The issue is whether the clinical infrastructure surrounding those services is sufficient to protect patients and support physicians in meeting their professional obligations.

For physicians, the most important question may be the simplest: "If something goes wrong, am I prepared to explain how I ensured this patient received safe, competent, and appropriately supervised care?" If the answer is yes, you are likely approaching the role with the level of diligence it requires. If the answer is uncertain, that uncertainty should be addressed before accepting the role, not after a patient is harmed.

In an environment where healthcare increasingly intersects with consumer services, technology, and entrepreneurship, physicians must remember that the setting may change, the business model may change, and the services may change. The physician's professional responsibility to the patient does not.

Executive Director Report

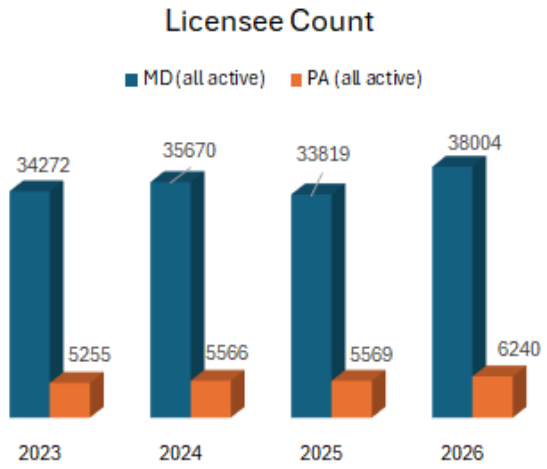
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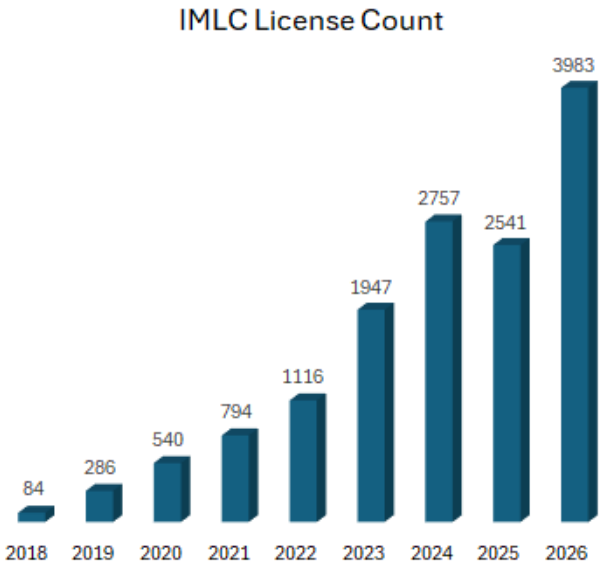
Kyle Karinen, J.D., LL.M

Several items for your collective consideration this quarter.

First, a quick check of the Commission's licensing numbers.



One trend that I think is indisputable is the increasing use of the Interstate Medical Licensure Compact (IMLC) by physicians.



When the IMLC was being formed well over a decade ago, the extent of use was absolutely hypothetical. For the Commission, it's been six years and the numbers continue to grow.

Second, the DOH (Department) has initiated rulemaking over fees for the licensees under the Commission's legislative mandate. For those new to this process, I'll offer a brief primer. By statute, authority over fees for all healthcare licensees is vested by statute with the Secretary of Health. State law mandates that each profession charge a fee for that profession to support their licensing, regulation, and rulemaking. On an on-going basis, the Department analyzes those expenses and outlays while also factoring in larger demographic changes and other risks. Last November, the Commission sent a letter to the Department recommending a reduction in renewal fees for physician and physician assistant credentials (The Commission subsequently recommended the changes also apply to certified anesthesiologist assistants). There are several unknowns with the regulatory landscape that made the Commission conservative in its recommendations and that landscape has, of course, evolved in the past ten months. With that in mind, the Department opened the rulemaking process this past summer and is working toward a time in the next few months for public engagement.

Demographics Dashboard

After much effort and work, the Commission has brought online a new demographics dashboard. The demographics survey included as part of the renewal process for physicians and physician assistants has been compiled for review. I encourage you all to take a moment and dive in. Many thanks to the Commission staff members, Nick Morris and Sherrise Martin, who marshaled this process of revamping the demographic data.

Passing of Maryella Jansen

Finally, I am going to end on a somber note this quarter. There are vast number of individuals who work for the Commission and have worked for the Commission in its current iteration. Behind the scenes of the Commission's operations in all forms are a group of dedicated civil servants executing the Commission's mandate of promoting the delivery of quality healthcare to residents of the State of Washington. Maryella Jansen was one of those individuals who not only shaped the Commission but also contributed mightily to the quality healthcare mission. Maryella passed away in August. A couple of long-time Commission staffers, Mike Farrell and Sherrise Martin, were kind enough to share their memories and thoughts of Maryella and I am sharing them with all of you:

"Former WMC Executive Director Maryella Jansen passed away last Friday after an illness. Maryella began her work with the Commission in the early 1990s as a compliance officer, was promoted to disciplinary manager, then deputy executive director. In 2013, the Commission convinced her to become the Executive Director because they knew that Maryella was the best person to lead the Commission staff through the pilot project because she had developed strong relationships with people across DOH. Simply put, people trusted Maryella. Maryella guided the Commission and Commission staff with dignity, wisdom, and compassion for each staff member. We owe a debt of gratitude to Maryella for creating the structure we all enjoy today. Maryella had a wicked sense of humor, laughed easily, and with a wink and smile, let you know that she didn't take the daily absurdities of work too seriously. She truly found joy in her work and in life. She will be missed by everyone who had the pleasure of knowing her."

Mike Farrell

"There are some people who come into our lives as coworkers or leaders, but leave behind a much greater impact. Maryella was one of those people. As the Executive Director, I had the privilege of working closely with her as her Administrative Assistant, as well as supporting the Deputy Director. From the very beginning, Maryella was someone who made you feel seen, heard, and valued. She always had an open ear and, more importantly, a genuine heart for every member of her staff. One of the things I will always remember was her morning walk-throughs. She would make her way around the office, stopping to say good morning and asking about our families. Those moments may have seemed small, but they meant so much. She truly cared about the people she worked with, not just the work we did. Maryella also knew how to bring fun and laughter into the workplace. She absolutely loved Halloween, and I will never forget her dressing up for our Halloween staff meeting and potluck. She had a wonderful way of reminding us that even in a demanding work environment, there was always room for a little laughter and joy. The beginning of the pilot project that eventually became the WMC was challenging. It was fast-paced, stressful, and, at times, overwhelming. But Maryella had a special way of making even the hardest days feel manageable. She could bring a sense of calm to the chaos and somehow find a way to make the work fun. Her leadership made a difference, not only in what we accomplished, but in how we experienced the journey along the way. Maryella truly loved her job and, even more so, she loved her staff. She believed in the people around her and encouraged us to learn, grow, and become the best we could be. I will always be grateful to Maryella for the guidance, encouragement, and knowledge she shared with me. She helped me learn so much and gave me the confidence to continue growing and becoming successful in my work. She was not only a wonderful leader and mentor, but a truly beautiful person. Her kindness, laughter, compassion, and genuine care for others are things I will carry with me. I feel incredibly fortunate to have had the opportunity to work with her and to have learned from her. You will always be remembered with love, gratitude, and great admiration."

Sherrise Martin

The Future Is Waiting in the Exam Room

Ed Lopez PA-C

"...even though I had a successful bicycle business and was building my first car in the privacy of the cellar in my home, I began to be pointed out as 'the fool who is fiddling with a buggy that will run without being hitched to a horse.' My banker called on me to say: 'Winton, I am disappointed in you.' That riled me, but I held my temper as I asked, 'What's the matter with you?' He bellowed: There's nothing the matter with me. It's you! You're crazy if you think this fool contraption you've been wasting your time on will ever displace the horse." Alexander Winton in an article dated February 8, 1930, in The Saturday Evening Post recalling his first horseless carriage that was built and sold on March 24, 1898, for $1000.00.

Ten Years later, Henry Ford officially released the first production Model T on October 1, 1908, with the first car shipped to a customer that same day which debuted at a price of $850 and selling 15 million cars in its 19-year run changing transportation and the world as it was forever, relegating horse ownership, after centuries, only as a hobby and a recreational pastime.

Today, we are yet again at another evolutionary juncture in America & the world, one which seems to scare the "bejabbers" out of some while others are rushing headlong with eyes wide shut into the abys of the unknown realm of electronic "intelligence" that has been labeled "Artificial Intelligence (AI)". As AI continues to enter every area of our lives it has most certainly entered the areas that you and I have spent years training in and even more years working in. The question we all wrestle with and debate over is, 'will AI replace what you and I do today or even replace us?' If the answer to either of these questions is yes, how will medical regulators and in particular the Washington Medical Commission manage and regulate that?

So let us examine for a moment how AI is being used in healthcare today according to the Dec. 22, 2025, Cleveland Clinic's "Health Essentials." AI is active in so many areas of healthcare delivery including:

Medical Imaging: Algorithms analyze X-rays, MRIs, and CT scans to flag early signs of conditions like breast or lung cancer, strokes, and sepsis.

Clinical Productivity: Generative AI tools and automated speech recognition "listen" to patient visits to instantly generate medical notes, allowing doctors to focus on the patient rather than paperwork.

Drug Development: AI models simulate biological systems and predict drug efficacy, drastically reducing the time required to develop new medications and vaccines.

Personalized Medicine: Systems combine electronic health records (EHRs) and genetic data to create customized treatment plans tailored to an individual's unique biology.

Operational Efficiency: Hospitals use predictive models to forecast emergency room surges, manage bed capacity, and optimize staffing, which reduces patient wait times.

Virtual Assistants & Wearables: AI-powered chatbots handle routine tasks like scheduling, symptom checking, and medication reminders, while wearable sensors track vitals for at-home chronic disease management.

All sounds good...right? But oh....wait...how about this:

"An advanced AI agent has outperformed human physicians on a series of demanding tests that assess the ability to correctly diagnose patient illnesses in clinical settings, a Harvard-led study found.
OpenAI's "o1 preview," the company's first model capable of step-by-step reasoning, proved that it could conduct real world triage in emergency rooms, recommend appropriate diagnostic tests, and perform case management tasks at a level that matched or surpassed the ability of even well-trained human doctors". Harvard Magazine 4/30/26

As AI continues to enter every area of our lives it has most certainly entered the areas that you and I have spent years training in and even more years working in. The question we all wrestle with and debate over is, 'will AI replace what you and I do today or even replace us?'

According to Digital Information World reporting on April 18, 2026, ***"A smaller but meaningful share of Americans use AI when faced with cost, access or quality barriers. For example, 14% of those who have recently used AI-generated health information say they used it because they were unable to pay for a doctor visit, 16% because they could not access a provider, and 21% because they felt dismissed or ignored by a provider in the past."***

"Regardless of the reason, almost half of Americans who have used AI for healthcare information (46%) say the AI tool or chatbot made them feel more confident when talking with or asking questions of a provider. Others claim that it helped them identify issues earlier (22%) or avoid unnecessary medical tests or procedures (19%)."

So…it appears that AI is involved in every aspect of the delivery of healthcare services and we must accept the fact that gone are the days when physicians went to our homes to treat us, or when insurance companies didn't tell us how long the pneumonia patient could remain in the hospital, or when emergency rooms were only for emergencies. But also, we share the world with a new generation of Americans that don't mind not interacting face to face with a human clinician for a variety of reasons! Yes… we have evolved and that evolution will continue, admittedly some for the better and some for the worse. And now artificial intelligence is here, knocking on our doors and changing the healthcare landscape yet again or still. So, do we ignore it or do we embrace it? I would suggest that we learn to manage it! And while I admit that we really don't know how far AI will take us or affect healthcare delivery, I would tend to agree that:

"***In the foreseeable future, AI will augment rather than replace physicians. The most realistic trajectory involves automation of well-defined tasks under human supervision, while clinical integration, physical examination, procedural performance, ethical judgment, and accountability remain physician-dependent. Future adoption should prioritize robust clinical validation, uncertainty management, escalation pathways to clinicians, and clear regulatory and legal frameworks"***. Diagnostics (Basel) 2026 Jan 26;16(3):396

The Washington Medical Commission realizes that there is much uncertainty in the world of healthcare delivery today. It continues to actively monitor the advancement and participation of machine learning and artificial intelligence as it affects the way that you and I do our jobs and how this may affect the citizens of Washington.

In conclusion, I leave you with a statement in the position paper from the Federation of State Medical Boards (FSMB) from April 2024 which offers a guiding principle to all state medical regulatory bodies in their executive summary:

"Artificial Intelligence (AI) holds tremendous potential to aid healthcare providers in diagnosis, treatment selection, clinical documentation, and other tasks to improve quality, access, and efficiency. However, these technologies introduce risks if deployed without proper "guardrails" and understanding which may impact considerations in clinical practice as well as regulatory processes of state medical boards. By taking a proactive and standardized governance approach anchored in ethical principles, state medical boards can promote safe and effective integration of AI, in its various forms, while prioritizing patient wellbeing".

"***It is not the strongest of the species that survives, nor the most intelligent, but the one most responsive to change.***" Charles Darwin

Navigating a New Vaccine Landscape: What Washington Providers Need to Know About Guidance

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Mahlet Zeru, MPH - Strategy Manager

Guided by decades of scientific research, childhood vaccinations have long been a stable and predictable cornerstone of preventive care.[1] Recent federal childhood immunization updates[2], however, have fractured a decades-long alignment between national standards, state mandates, and pediatric societies.[3,4,5] To help healthcare providers navigate this complex landscape and protect patient equity particularly for historically underserved communities vulnerable to fragmented care and coverage gaps, Washington state has formed the West Coast Health Alliance[6] alongside new legislation preserving access to preventive services.[7]

Federal Guidance

In January 2026, the Centers for Disease Control and Prevention (CDC) revised the federal childhood immunization schedule following a federal review of vaccination practices.[8] The revised framework reduces the number of vaccines universally recommended for all children and organizes immunizations into categories that include universal recommendations, recommendations for certain high-risk groups or populations, and recommendations based on shared clinical decision-making.[9]

The American Academy of Pediatrics (AAP) subsequently issued its own 2026 childhood and adolescent immunization schedule and no longer endorses the CDC schedule[10]. The AAP maintains broader routine childhood immunization recommendations based on its comprehensive review of vaccine safety, effectiveness, disease epidemiology, and disease burden.[11]

For providers and families, this creates an unusual environment where authoritative sources now offer conflicting recommendations.[12] This divergence places a heavier responsibility on states, healthcare systems, and providers to interpret changing guidance and communicate clear, actionable information to patients.[13]

As vaccine recommendations become less uniform, healthcare providers play an important role in ensuring that changing guidance does not create new barriers to care.

State Coordination

Against this backdrop of federal public health shifts, several West Coast states have developed an alternative approach to reviewing scientific evidence and coordinating public health guidance.[14]

In September 2025, Washington, California, and Oregon created the West Coast Health Alliance (WCHA), with Hawai'i joining shortly afterward.[15]

The Alliance formed amid changes in federal public health leadership, vaccine policy, advisory processes, and the composition of the CDC's Advisory Committee on Immunization Practices (ACIP).[16]

The WCHA does not replace federal agencies or individual state authorities.[17] Instead, it provides participating states with an additional mechanism to review scientific evidence and coordinate guidance using recommendations from established medical and scientific organizations.[18] The Alliance issued coordinated COVID-19, influenza, and RSV recommendations in September 2025 and later endorsed the AAP's 2026 childhood and adolescent immunization schedule.[19,20]

For Washington providers, the WCHA offers an additional evidence-based resource when federal, state, and professional recommendations diverge.

Preserving Access

Alongside regional coordination, Washington has taken legislative action to clarify how the state develops vaccine recommendations and preserves access to preventive services as federal guidance shifts. Governor Bob Ferguson signed Engrossed Substitute House Bill 2242, Preserving Access to Preventive Services, on March 9, 2026, with immediate effect.[21,22]

- State Authority: HB 2242 grants the Washington DOH explicit authority to issue state immunization recommendations and related guidance. DOH continues to consider ACIP recommendations while also factoring in guidance from other expert organizations relying on reasonable scientific evidence.[23]

- Coverage Alignment: The legislation connects recommendations directly to access. For health plans subject to Washington insurance regulations, specific vaccine coverage requirements are now tied to vaccines recommended by the Washington DOH rather than exclusively to ACIP recommendations.

Together, the WCHA and HB 2242 provide Washington with a robust framework to evaluate vaccine evidence, issue state-specific recommendations, and preserve access amidst shifting federal policy.

Equity

As vaccine guidance grows more complicated, navigating conflicting recommendations becomes an equity barrier, disproportionately burdening families with limited healthcare access, language hurdles, or unstable insurance.[24,25,26,27] Shared clinical decision-making currently encouraged by the CDC guidance[28], requires patients and families to understand information and have adequate time with the provider to ask questions. Complicated vaccine systems can increase the burden on families limiting access further and widening existing dipartites.[29,30,31]

As vaccine recommendations become less uniform, healthcare providers play an important role in ensuring that changing guidance does not create new barriers to care.[32] Staying current with Washington DOH recommendations[33] is essential as well as recognizing how language, disability access, insurance instability, transportation, work schedules, and other barriers can affect a family's ability to act on those recommendations.[34] By identifying barriers, communicating clearly, and supporting informed decision-making, providers can help ensure preventive care remains understandable and accessible.[35,36] As vaccine guidance evolves, we must ensure that increased complexity does not lead to greater inequity, allowing everyone to continue benefiting from low rates of vaccine-preventable diseases.[37]

New Medical Cannabis Authorization Form required by September 1, 2026

This is an important update for healthcare practitioners (HCPs) who authorize the medical use of cannabis.

Starting September 1, 2026, the updated version of the Medical Cannabis Authorization Form (PDF) will be required. Last year, the Department of Health (DOH) made updates to the form to include no longer identifying the specific patient condition and for the HCP to acknowledge that the first office visit must be in person.

Please use the updated form as soon as practicable. If you have stock of tamper-resistant paper on an older form, you may use it until the September 1st deadline.

For more information about authorizing medical cannabis, see the DOH's Medical Cannabis - Healthcare Practitioners webpage and FAQ. You'll find topics such as:

- Your legal requirements for authorizing medical cannabis.
- Tamper-resistant paper requirements specific to medical cannabis authorizations.
- Medical Cannabis Authorization Guidelines
- Guidance for a Valid Medical Cannabis Authorization Form

If you have any questions, please contact MedicalCannabis@doh.wa.gov.



Empowered by Choice: WPHP's Voluntary Model

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

The Washington Physicians Health Program (WPHP) is an independent, physician-led, nonprofit organization providing early intervention, assessment, treatment referral, and post-treatment health support for health professionals in need. WPHP is contracted by the Washington State Department of Health to serve as the authorized physician health program serving allopathic, osteopathic, and podiatric physicians, physician assistants, dentists, veterinarians, as well as students and residents of these professions.

WPHP has a dual purpose to protect patient safety and support health professionals. We serve as a voluntary, confidential resource for medical professionals with impairing health conditions that include mental health, non-psychiatric medical conditions, and substance use disorders. Every day, we navigate complex situations where the health of medical professionals and the safety of patients are both at stake. Our role is to provide confidential health support while making thoughtful, evidence-based decisions that uphold our responsibilities to participants, the medical community, and the public, contributing to a stronger and safer healthcare system overall.

Participation in WPHP is voluntary. WPHP cannot compel a physician or PA to enter or remain in the program. Because voluntariness is foundational to our mission, and to the boundaries of our responsibility and accountability, it warrants explication here.

Let us begin by acknowledging that many who are referred to WPHP face real external pressure to participate: an employer, credentialing entity, or regulator may attach consequences to the individual's decision, whether as a condition of continued employment, privileging, or licensure. In this sense, participation is often more externally than internally motivated, at least at the outset. But external motivation does not render a choice involuntary. In our view, a prospective participant always retains the choice to enter WPHP or not and retains, in full, the right to contest any employment, credentialing, or regulatory decision through the appropriate channels.

That choice is a real one. An individual may decline to participate or later withdraw, and WPHP imposes no penalty for that choice. Where WPHP is monitoring a participant, it may report a withdrawal or noncompliance to the referring or regulatory entity—not as a penalty, but as part of the disclosed monitoring and reporting function agreed to at the outset. And where an individual declines or does not follow WPHP recommendations and poses a risk to patient safety, WPHP has a legal obligation to notify the Washington Medical Commission (RCW 18.130.175). Any consequence that follows is imposed by the third party exercising its own independent responsibilities. WPHP, in short, is not the source of the pressure a participant may feel. And while an individual's participation (or non-participation) may inform the decisions of employers, credentialing bodies, and regulators, it does not make WPHP responsible or accountable for them.

A second dimension of WPHP's voluntariness is informed consent. For a decision to participate to be genuinely voluntary, prospective participants must be fully informed of the risks, benefits, and alternatives of program participation, including the implications of choosing not to participate. Washington law reinforces this: WPHP is required by statute to inform participants of the program's procedures, the responsibilities of participation, and the possible consequences of noncompliance (RCW 18.71.320(5)). We make every effort to ensure that anyone contemplating participation has the information needed to make an informed decision, including detailed information available on our website and a structured, two-part informed consent process at program entry. By making the process transparent from the outset, we help ensure that the decision to participate is a deliberate and informed one.

Fear, shame, stigma and denial are powerful impediments to recognizing and addressing concerns of impairment proactively. Prior to the development of PHPs, an ill physician was often out of options once a career or life ending event occurred. WPHP offers physicians and PAs an opportunity to address concerns for impairment in a manner that preserves career, reputation, health, and safe practice. This opportunity has always been a choice.

For 40 years, WPHP has been committed to our mission of supporting the health and well-being of medical professionals and protecting patient safety. WPHP delivers trusted, credible, and timely advocacy when participants need it most. In fact, 88 percent of program participants report needing and benefiting from WPHP advocacy.[2] WPHP also continues to make tremendous strides locally and nationally in advocating license and credentialing question reforms and addressing other systemic barriers to mental health and well-being.

To learn more about WPHP, or if you or a colleague need help, please visit our website or call 800-552-7236. Follow us on Facebook and LinkedIn for the latest insights and resources in physician health.

References:

1. AMA Code of Medical Ethics Opinion 9.3.1 and 9.3.2: https://code-medical-ethics.ama-assn.org/chapters/professional-self-regulation
2. Washington Physicians Health Program 2025 Annual Report: https://wphp.org/wp-content/uploads/2026/04/wphp_annual_report_2025_final.pdf

Rulemaking Efforts

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Amelia Boyd
Program Manager

In Progress

WAC 246-921-125 – Renewal, Continuing Medical Education Cycle, and Maintenance of Licensure for Certified Anesthesiologist Assistants

The Commission is considering amending WAC 246-921-125 to align the anesthesiologist assistant CME renewal cycle with the PA cycle. The Preproposal Statement of Inquiry, or CR-101, was filed on May 13, 2026, as WSR #26-11-021. One workshop was held on August 24, 2026, where the proposed language was approved to go to the next step in the rulemaking process, CR-102 or proposed rulemaking. The request to initiate the CR-102 will be made at the WMC's next Business meeting scheduled

for November 20, 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 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 are ongoing. Please visit our Rules in Progress page for the current schedule.

Establishing the clinical experience graduate pilot program to implement Substitute Senate Bill (SSB) 5185 (Chapter 154, laws of 2026)

A CR-101, Preproposal Statement of Inquiry, was filed on June 25, 2026, as WSR #26-14-046. The WMC is considering adding new sections to chapter 246-919 WAC to establish a limited license for international medical graduates and a pilot program to allow supervised practice as a pathway to full licensure, to implement SSB 5185. Two workshops were held, the second on August 3, 2026, where the proposed language was approved to go to the next step in the rulemaking process, CR-102 or proposed rulemaking. The request to initiate the CR-102 was made and approved at the WMC's August 21, 2026, Business meeting. Please visit our Rules in Progress page for more information.

Upcoming Rulemaking

Chapter 246-918 WAC – Physician Assistants

Under RCW 43.70.041, the Department of Health (DOH) is required to establish and conduct a formal review of its existing rules every five years. The purpose of this review is to identify opportunities to simplify and streamline rules, reduce regulatory burden, and ensure that rules continue to protect public health and safety. Earlier this year, WMC staff conducted a five-year review of Chapter 246-918 WAC, which governs the practice of physician assistants. Staff's review focused on WAC 246-918-005 through WAC 246-918-420. The review identified several areas where the existing rule language could be updated, clarified, or revised to better align with current statutes, regulatory practices, and the current practice of physician assistants. Staff also identified provisions where language could be modernized while maintaining appropriate standards for safe and effective practice.

At their August 21, 2026, Business meeting, Commissioners approved initiating standard rulemaking on WAC 246-918-005 through WAC 246-918-420. Please visit our Rules in Progress page for more information.

Recently Completed Rules

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

The Commission adopted amendments to WAC 246-919-601 and adopted a new section, WAC 246-919-603, to establish the use of nitrous oxide in office-based settings. The commission adopted these rules to address a gap in existing regulations and to ensure consistent safety standards for the use of nitrous oxide in office-based settings. Previous rule WAC 246-919-601 did not clearly state whether nitrous oxide qualified as minimal sedation, creating uncertainty for physicians. The new section, WAC 246-919-603, resolves this ambiguity by defining when nitrous oxide use may be exempt and by establishing clear conditions for its safe administration.The CR-103, or Permanent Rulemaking Order, was filed on May 13, 2026, as WSR #26-11-022. The WSR document contains the adopted rule language, which will take effect on June 13, 2026.

Rulemaking Rescinded

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.

Since the CR-101 was filed, current practice, interested party input, and the regulatory landscape surrounding collaborative drug therapy agreements have continued to evolve. As a result, the scope and policy considerations that would need to be addressed today are substantially different from those contemplated when the CR-101 was filed in 2020.

The CR-101 has remained open for approximately six years without advancing to the Proposed rule stage. If the Commission determines that rulemaking related to collaborative drug therapy agreements is warranted in the future, the issues under consideration would be significantly broader and materially different from those identified in the original CR-101. Consequently, staff would recommend filing a new CR-101 to clearly define the purpose, scope, and objectives of any future rulemaking and to provide interested parties with appropriate notice and opportunity to participate.At their August 21, 2026, Business meeting, Commissioners voted to rescind the CR-101 initiated under WSR #20-16-008.

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.

Upcoming Events

- Oct 08 - Personal Appearances
- Oct 12 - Chapter 246-919 WAC, Allopathic Physicians
- Oct 29 - Policy Committee
- Nov 09 - Chapter 246-919 WAC, Allopathic Physicians
- Nov 11 - Veterans Day: WMC Offices Closed
- Nov 19 - Personal Appearances
- Nov 20 - WMC Business Meeting
- Nov 20 - WMC Lunch & Learn
- Nov 26 - Thanksgiving Day: WMC Offices Closed
- Nov 27 - Native American Heritage Day: WMC Offices Closed
- Dec 03 - Policy: Interested Parties
- Dec 25 - Christmas: WMC Offices Closed

All Upcoming events can be found on our website.

Legal Actions

WASHINGTON Medical Commission
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May 1, 2026 – July 31, 2026

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				
Berg, Tracy A., MD MD00032615 Spokane County	Order of Summary Suspension	7/13/26	Relinquishment of license in Colorado.	Indefinite suspension.
Curcin, Aleksandar, MD MD60199604 Clark County	Order on Show Cause Hearing	5/5/26	Inability to practice with reasonable skill and safety due to a health condition.	Prohibited from engaging in direct or indirect patient care and treatment.
D'Abbracci, Patrick J., MD MD00045396 King County	Order of Summary Suspension	5/26/26	Inability to practice with reasonable skill and safety due to a health condition.	Indefinite suspension.
Dattel, Frederick S., MD MD60662970 Out of state	Order of Summary Suspension	6/4/26	Suspension of license in Florida and surrender of license in California.	Indefinite suspension.
Denor, Joseph, MD MD60542290 King County	Interim Stipulated Order Restricting Practice	6/8/26	Alleged potential inability to practice with reasonable skill and safety due to a health condition.	Practice restricted pursuant to recommendations by Pine Grove Behavioral Health Professional Enhancement Team report.
Farrag, Yasser E., MD MD60735395 Out of state	Order of Summary Suspension	6/11/26	Surrender of license in California.	Indefinite suspension.
Frederickson, Abby N., MD MD61478865 Out of state	Order of Default	5/15/26	Suspension of license in Colorado.	Indefinite suspension.
Harrison, Frank G., MD MD61172841 Out of state	Order of Summary Suspension	7/14/26	Surrender of license in North Carolina.	Indefinite suspension.

Practitioner Credential and County	Order Type	Date	Cause of Action	WMC Action
Formal Actions				
Jordan, Timothy W., MD MD00046301 Spokane County	Agreed Order	7/9/26	Negligent treatment and inadequate documentation of treatment of children with autism, dyslexia, ADHD, and other conditions.	Clinical competency assessment and completion of all recommendations; completion of course in managing high impact emotions for healthcare professionals; record keeping course; course in patient/family communication and diagnostic reporting to schools; paper on learnings from courses; if practicing in a hospital or clinical setting, must arrange for another physician to serve as a mentor for three months; notification to employer; personal appearances; personal reports; fine. May petition to terminate in three years.
Krause, David E., MD MD61654643 Out of state	Agreed Order	7/9/26	Failure to report deferred prosecution for reckless driving when applying for letter of qualification in Illinois when seeking eligibility for compact licenses in other states; prescribing opioids and benzodiazepines to family members; misrepresenting facts during an investigation; failing to produce requested documents during investigation.	Indefinite suspension.
Milam, Phillip E., MD MD00039262 Pierce County	Agreed Order	7/15/26	Failure to provide records to a patient's new provider; prescribing ivermectin to a patient with underlying health conditions creating high risk of developing complications from a COVID-19 infection; failure to cooperate with investigation.	Course in record keeping;develop procedure for fulfilling records requests from patients; compliance audits; personal appearances; fine; may petition to terminate in two years.
Mundall, Jon M. R., MD MD00023408 Franklin County	Agreed Order	5/12/26	Misdiagnosing of thyroid disease, inappropriate prescribing of thyroid medications; inadequate monitoring;	Voluntary surrender of license.
Sajan, Javad A., MD MD60430545 Snohomish County	Agreed Order	7/2/26	Requiring patients to sign agreement not to post negative reviews.	Ethics and boundaries course; reflective paper; compliance audits; personal appearances; fine. May petition to terminate in two years.

Practitioner Credential and County	Order Type	Date	Cause of Action	WMC Action
Formal Actions				
Shaw, David P., MD MD00031334 King County	Order of Summary Restriction	6/18/26	Alleged inappropriate prescribing of controlled substances and inadequate documentation and lack of appropriate monitoring of patients receiving ketamine.	Restricted from prescribing controlled substances
Snyder III, Edward J., MD MD60831955 Out of State	Order of Automatic Suspension of IMLC license	6/25/26	Suspension of license in Illinois.	Indefinite suspension.
Tran, Ngoc Huu Quynh PA60363177 King County	Agreed Order	5/27/26	Inability to practice with reasonable skill and safety due to a health condition.	Enter into health support agreement with WPHP; psychotherapy; collaborating physician chart review; obtain a primary care provider; personal appearances; may petition to terminate in one year.
Turner, Michael K., MD MD60072206 Benton County	Order of Default	5/29/26	Failure to cooperate with investigation.	Indefinite suspension.
Yousaf, Haroon , MD MD61041218 Thurston County	Agreed Order	7/9/26	Writing three prescriptions on a prescription pad from his previous employer; providing username and password to employees to access patient records for billing and administrative purposes; directing non-clinical staff to contact patients; allowing an employee to meet with a patient and complete a form describing symptom management goals.	Ethics course; course in HIPAA privacy and security; paper; develop office protocol for prescription security and form control; compliance audit; personal appearances; fine. May petition to terminate in two years.
Informal Actions				
Cao, Stephanie Q., MD MD61253922 Whatcom County	STID	7/9/26	Alleged failure to refer patient to a neurologist to evaluate symptoms of a neurological disorder resulting in the patient receiving a delayed diagnosis of ALS.	Course in communication; paper on recognizing the symptoms of Bulbar ALS and the benefits of early diagnostic testing; peer presentation; personal appearances; costs. May petition to terminate in two years.
Fleischman, Sally S., MD MD00041544 Kitsap County	STID	5/7/26	Alleged failure to address and document a patient's alcohol use who was on high doses of opioids.	Course in pain management, opioid addiction management, and suboxone management; paper; registration with PMP; compliance audits; personal appearances; costs. May petition to terminate in two years.

Practitioner Credential and County	Order Type	Date	Cause of Action	WMC Action
Informal Actions				
Fritz, Anthony W., MD MD00028202 Lewis County	STID	5/7/26	Alleged inadequate documentation of treatment of chronic pain patients.	Course in prescribing controlled substances; course in record keeping; paper; registration with PMP; compliance audits; personal appearances; clinical competency assessment; costs. May terminate in three years.
Jensen, Frederick A., MD MD00028618 Thurston County	STID	7/9/26	Alleged failure to provide medical records to a patient, after being subject to a STID for a similar allegation.	Develop office policy and procedure regarding how patients may obtain copies of records; review WMC policy on medical records; compliance audits; personal appearances; costs. May petition to terminate in two years.
Le, Nhu Quynh Q. MD60616742 Kitsap County	STID	5/7/2026	Alleged substandard care to three patients in a hospital emergency department.	Clinical skills assessment; practice approval by WMC if returning to Washington; course in record keeping; paper; personal appearances; costs. May petition to terminate in four years.
Martin, Andrea N., MD MD60636201 Mason County	STID	7/9/26	Alleged interference with procedure by discouraging two surgical team members from participating in procedure.	Course in ethics and boundaries; paper; personal appearances; costs. May petition to terminate in two years.
Niemeyer, Agnieszka, MD MD00048475 Clallam County	STID	5/7/26	Alleged employing of 18 persons as medical assistants without licenses and allowing one to inject Botox; billing patients who were seen when Respondent was not in the office; and engaging in aggressive and erratic behavior.	Course in ethics; course in communication; course in disruptive behavior; paper; compliance audit; personal appearances; costs. May petition to terminate in two years.
Tobin, Jennifer A., PA PA10004894 Out of state	STID	7/9/26	Alleged inability to practice with reasonable skill and safety due to a health condition.	Continued participation in the Oregon Health Professionals' Service Program; comprehensive assessment; practice site approval; personal appearances; costs. May petition to terminate in three years.
Zhang, David Y., MD MD60457085 King County	STID	7/9/26	Alleged failure to meet standard of care in treatment of two patients undergoing invasive cardiac procedures	Restricted from performing invasive cardiac procedures; clinical competency assessment, and following all recommendations; course in communication; paper; personal appearances; costs. May petition to terminate in three years.

Technology Corner

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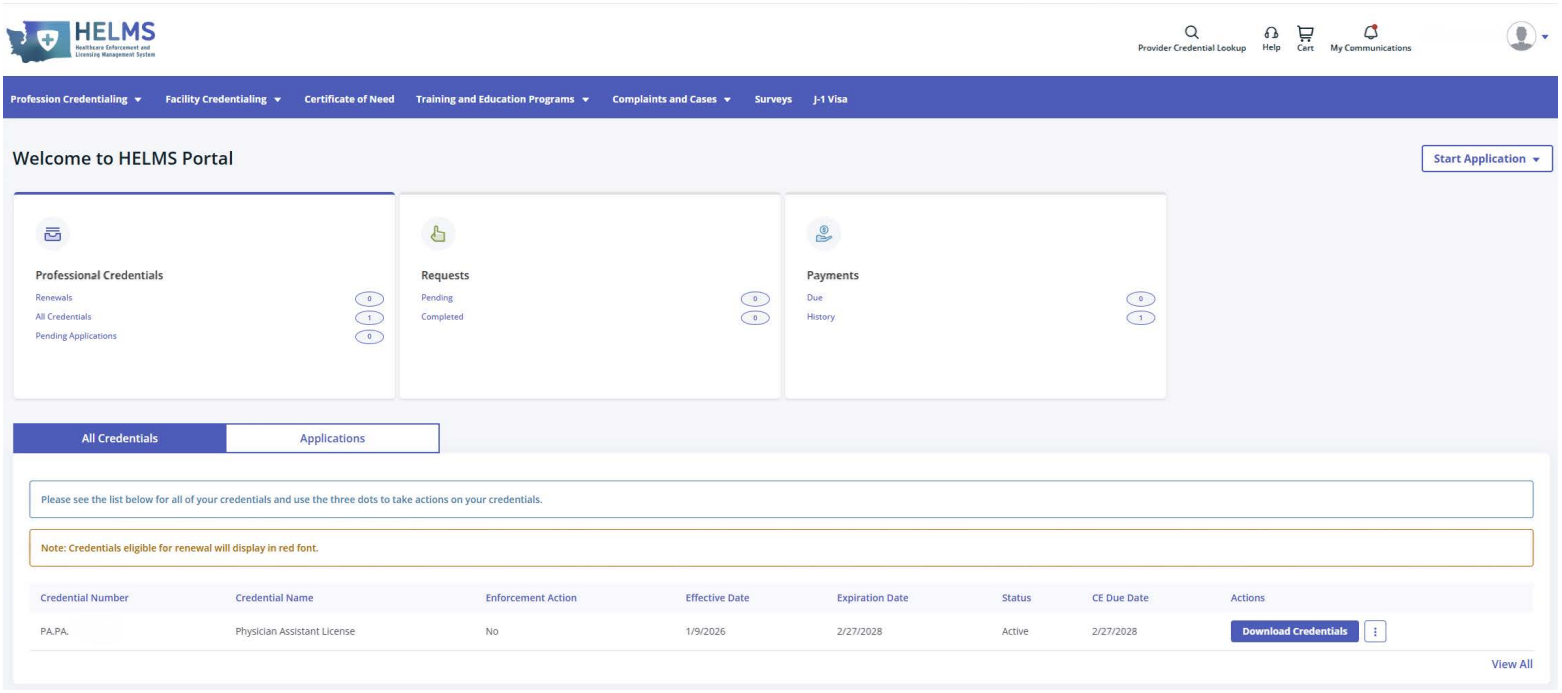
The WMC has gone through a lot of changes as a result of a new licensing and enforcement database known as HELMS. This transition has fundamentally changed the way we conduct business and how you, the licensee, interact with your commission. From how applications are submitted to how renewals, complaints, and investigations are tracked, many of the processes you were used to have been reworked, and we know that adjusting to a new system can raise questions. In the Q&A that follows, we've gathered some of the most common questions we've received from licensees since the transition and answered them as clearly as we can. If you don't see your question addressed here, please reach out. Your feedback helps us improve the system and shape future issues of this newsletter.

Q1. How can I find out where I am in my four-year cycle for completing my 200 hours of CME to maintain my Washington State physician license?

A1. Log in to your HELMS Dashboard through your Secure Access Washington (SAW) account. There you'll see a list of your credentials along with your CE due date.

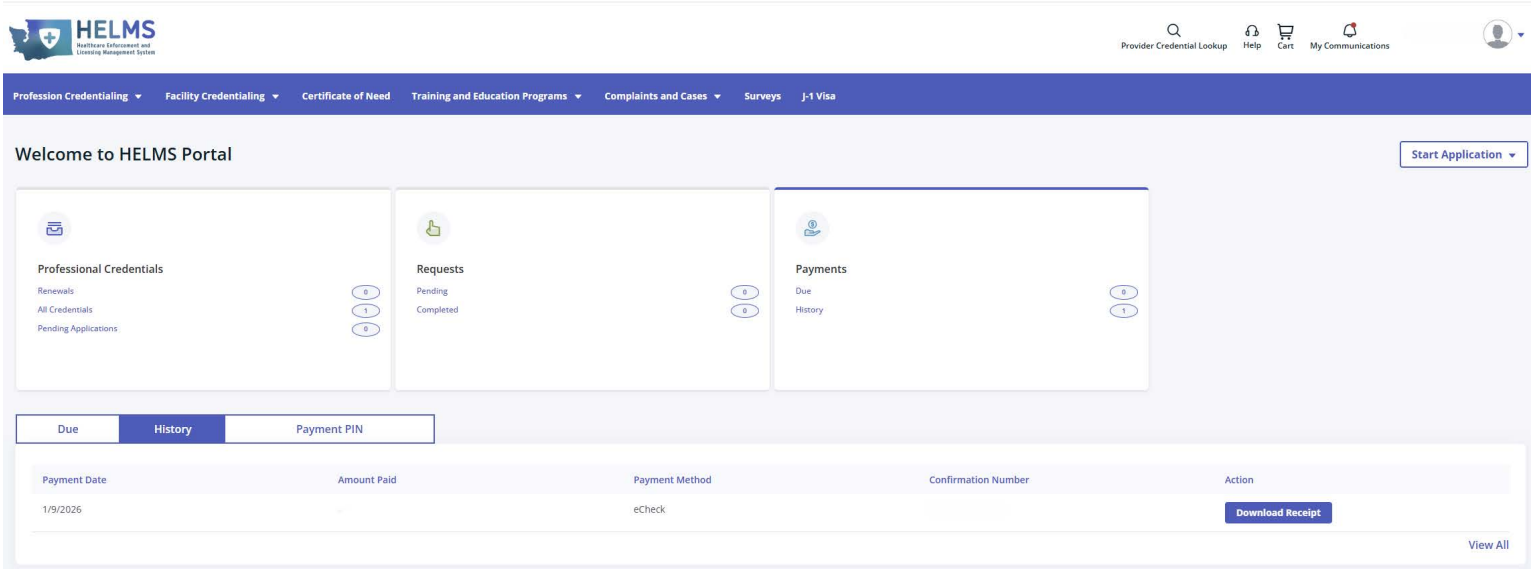
Q2. I need a copy of my current Washington State medical license for a credentialing update with my online care group.

A2. You can download your license from the Credentials tile on your HELMS Dashboard, located next to the CE due date.



Q3. I am hoping to have my medical license fee reimbursed by my employer, but they require a receipt or invoice showing the $511 I paid with my initial application. Can you help?

A3. From your HELMS Dashboard, click the Payments tile to see your current and past payments. Under the History tab, you'll find a button to download your receipt.



The DOH no longer mails renewal notices, so now is a good time to make sure that you have the correct, valid email address updated in your profile. For more additional resources, please visit the DOH HELMS webpage.



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WMC Mission

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

WMC Vision

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

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