Washington Medical Commission

UPDATE!

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Message from the Chair

WASHINGTON **Medical Commission**
Licensing. Accountability. Leadership.

We See You

Terry Murphy, MD

I was very recently in a sunny golf community for winter vacation when sirens blared and then a medical helicopter came into view in the distance. I uttered a silent prayer that everyone involved would be alright.

Two days later, I learned it was someone my husband and I knew and had spoken to that week. His wife had expressed worry that her husband had a shoulder injury and wouldn't seek medical attention. The pain had kept him from golf and other activities he really enjoyed. My husband had recovered from his own shoulder injury, and I gently spoke to him and encouraged him to see a provider. Symptoms could be evaluated, treated, and he could get back to the golf he loved. He nodded and said he'd think about it.

We learned later, he was hiking in the community, collapsed and was found by another hiker. Pulseless and apneic, efforts to revive him from bystanders waiting for paramedics were unsuccessful. He was pronounced dead short time later at the local hospital: an apparent fatal myocardial infarction. All the sirens and air support assistance couldn't help our friend. His memorial service is today and the community is gutted.

Questions remain for me. Was the shoulder pain and anginal equivalent? Could I have done more? This friend was not a patient. He didn't seek my advice or even ask my thoughts....

Currently as I process this, it's a reminder of meeting people where they are. According to US surveys, nearly 1/3 of people never go to the doctor even when they are concerned something might be wrong. There are a myriad of reasons for this including being under or uninsured, fear, and mistrust. I recently heard a quote "Great harm can occur without any malicious intent".

> ***"Complaints against MDs and PAs are at an all-time high in WA. Influencers are trusted by some more than competent medical professionals"***

There is great mistrust in the medical system at this time. Complaints against physicians and physician assistants are at an all-time high in Washington state. Influencers are trusted by some more than competent medical professionals. These influencers tend to stand on and perpetrate medical misinformation. We, the Commission, understand many of the complaints involve:

- Communication issues.
- System problems such as short staffing, long wait times, cold exam rooms, thin walls.
- Unhappiness with other staff including receptionists, nursing, or billing people.

Seventy percent of complaints received are closed, often for these reasons. The challenges are great. My message from the Commission is "We see you". The twenty-one commissioners remain completely committed to upholding the mission, "to promote patient safety, enhance the integrity of the medical profession, and advance the optimal level of medical care for the people of Washington".

We are grateful for the dedication and grit as you show up every day for your patients. I was reminded of this several weeks ago when I became "the patient" for major joint replacement. I am grateful for:

1. The pre-op nurse who started my IV on the first try.
2. The nurse anesthetist, who put me at ease before general anesthesia and intubation.
3. The excellent orthopedic surgeon and surgical team who did everything right in the operating suite.
4. The recovery nurse and physical therapist who helped me meet the milestones for a safe discharge the same day.
5. And the physician assistants who evaluated me in post operative visits.

Sorry for the ramblings of this latest message from the Chair. But I sincerely hope we all strive to never be the reason someone refuses to ever see another provider. We take that moment to smile, be compassionate, and ask the patient to partner in their care. And for the vast majority of our licensees who are the competent, caring, and dedicated professionals we all want for our family members and ourselves, we thank you.

Executive Director Report

Kyle Karinen, J.D., LL.M

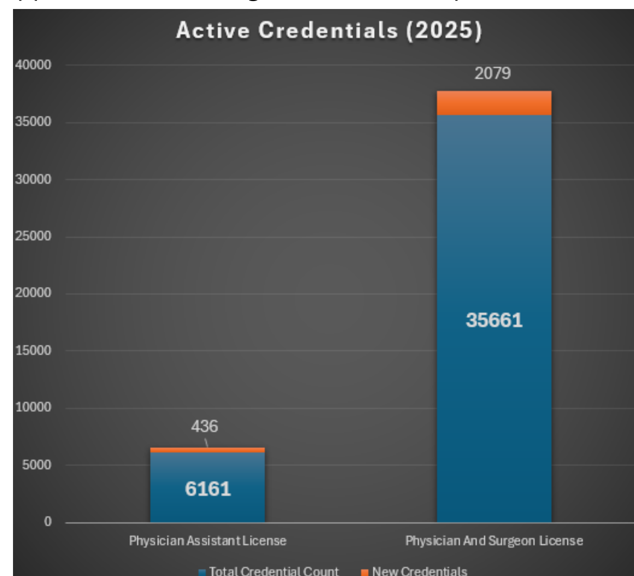
The Future

The Commission was recently invited to speak to a group of medical students and residents. The presentation itself was the normal sort – what the Commission is, who the Commission is, and what the Commission does. We do this sort of presentation in one form or another half a dozen times a year in a variety of venues. This one also focused on the intersection of the Commission's work in the policy realm whether it be in rules, legislation, or guidance. On the Commission side, it was myself and the Commission's medical consultant, Dr. Gina Fino. Aside from the informational aspects of the presentation, the attendees had questions about Dr. Fino's work as a licensed physician with a regulatory body. It's always a little daunting as a non-clinician to speak to these audiences, but at the conclusion, I took the opportunity to chat briefly with the audience about the importance of communication with patients. The Commission receives anywhere between 1800 and 2400 complaints annually. If there is a single through-line over the past 18 months, there has been a steady flow of complaints where communication between patients and their physicians and physician assistants was a contributing factor to the complaint. I am sure none of that is news to the licensees out there. The Commission has talked repeatedly about this topic over the years – please see this article from then-Chair of the Commission, John Maldon. When I have spoken to Commission members over the years and asked them what sort of training they received in medical school or PA training with respect to communication skills, there was noticeable difference in responses along demographic lines. Later career physicians or PAs? Not much time, if any, was meaningfully spent on how to communicate with patients. Fast forward to modern medicine and all the challenges physicians and PAs face – increased patient panels, insurance requirements, apps, Dr. Google, emails, chats, et cetera. I am generally loathe to add yet another aspect to the crush of the things licensees need to pay attention to, but it feels like we're losing something as healthcare evolves. The complaints received by the Commission bear this out. Even if one of these medical students or residents remembers my quiet 30 second plea as they engage with a patient once they have their white coat or complete their residency, it felt worthwhile.

HELMS

After an arduous process, the Department will soon finalize the transition to the Healthcare Enforcement and Licensing Management System (HELMS) from an older legacy system. It has been a long path and not without expense to the DOH and the over 80 healthcare professions and licensed facilities. The most public face of this process for individual physicians and physician assistants – licensing and renewal – transitioned last April. The rollout was not without its bumps in the road, for sure. (One of the more succinct comments came early on – "No".) The Commission's licensing staff has worked tirelessly to assist applicants, licensees, residency directors, and hospital administrators over the last 11 months and I want to say thank you to them in this space. As with many information technology projects of this size and scope, you cannot predict with certainty what might go awry when you flip the switch and put it online. The Commission's licensing staff have represented the very best in civil service in challenging circumstances.

The second major part of this rollout may have actually occurred by the time you read this, but the system is scheduled to go dark on March 18 and come back online on March 24. This rollout will implement a new complaint intake, investigation, and legal case management system – out of sight for the vast majority of applicants and licensees, but important to the Commission's basic statutory mandate from the Legislature, nonetheless. As the system matures, the Commission is dedicated to providing the very best service it can to licensees and applicants. Please do not hesitate to contact the Commission or me directly (kyle.karinen@wmc.wa.gov) with suggestions for improvement and thank you for your collective patience, support, and encouragement over the past 11 months.



WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

"Fake It Till You Make It"

Ed Lopez PA-C

In the 2002 Spielberg film "Catch Me if You Can" the lead protagonist Frank Abagnale played by Leonardo DiCaprio goes through life playing multiple characters as a con man including portraying a pilot for Pan American airways, a Louisiana lawyer and a local physician. Ultimately he is exposed throughout all of his cons and is chased and apprehended by the FBI, tried, convicted and sentenced to prison.

As I thought about this film that was loosely based on the real life story of con man Frank Abagnale, I couldn't help thinking about the term "fake it till you make it" so once commonly used in the youthful ambitious sales corners of the Southern California real estate market just before the 2008 sub-prime mortgage fiasco and the meltdown that nearly brought down our entire US economy. Basically, as some of you may recall, these supposed "salespeople" were an army of mostly young, overly ambitious, 30 somethings wearing designer suits, driving rented European cars, and talking loudly on leased cell phones at Starbucks so everyone could hear them closing their latest million-dollar house deal in LA & Orange Counties. In that act, they demonstrated to their listening and watching double shot latte buzzed "audience" that they were really successful entrepreneurs! Well… ultimately, many of us remember what happened as the whole thing was exposed and it all came crashing down like a house of cards nearly bankrupting our nation's economy and leading to the American Recovery & Reinvestment ACT.

"The United States today, appears to be in a healthcare crisis with increasing healthcare costs, demands, a shrinking number of working physicians, a growing trend of Wall Street health system mergers and acquisitions, the increasing trend of de-personalizing the physician- patient experience prompting worsening patient satisfaction"

By now you are probably asking, why are we reading about this in a Washington Medical Commission newsletter? Well, stay with me for a moment and I will explain.

The United States today, as we are all aware, appears to be in a healthcare crisis with increasing healthcare costs, increasing healthcare demands by Americans, a shrinking number of working physicians, a growing trend of Wall Street health system mergers and acquisitions, the increasing trend of de-personalizing the physician- patient experience prompting worsening patient satisfaction while at the same time embracing artificial intelligence to replace many common physician tasks and duties in the name of "efficiency". And amid this landscape comes you and I. Physician Assistants, recently changed in some jurisdictions as Physician Associates or as we are referred to in some circles euphemistically as APP's. And as our numbers grow in our state I will share with you a concern that I wish for all of us to be mindful of.

Anecdotally there appears to be a growing number of complaints by patients about MD's and PA's which obviously gives me pause to consider as to why. Complaints about behavior and competence. And while we all would acknowledge that PA education today is rigorous, expensive, demanding and all absorbing, what is important to remember is that once you have graduated, passed your boards, applied and received your license to practice, sought and found that first job as a clinician to "stomp out disease" and help each patient that walks in the door of the clinic or hospital, you must understand that wearing that white coat with the stethoscope around your neck does not give you the authority or the expertise to assess and treat the potential life-threatening disease or illnesses that you will encounter in a moment.

One of the greatest powers and assets in a skilled professional is not that he or she is the smartest person in the room or pretends to be, but that he or she has the emotional intelligence to acknowledge their shortcomings, their faults and their areas of knowledge inadequacy with the insight to realize what you do not know.

As we all know, the art and science of medicine is such a wonderful career because you can never master it. However, because of its evolution and continual sense of discovery, research and exploration we are unable to keep up with the art and science of medicine, so we are always students of medicine, always learning and experiencing overtime new and exciting clinical information.

Today, in the current cultural climate of complaints related to PA's and all caregivers, I am urging all of my colleagues irrespective of your education or experience that you remember as you enter the room or sit by the bedside of the sick and injured patient, that you first always consider and value the importance of compassion, kindness, the ability to listen rather than to speak, to first "do no harm", to know your limitations and know when to ask for the help and assistance that you need to ensure that the life you are now responsible for gets the best care that they require and deserve. We must forever seek and embrace humility not as weakness but as strength. The patients that we see each day are not interested in what school you attended or how many letters are printed after your name. What our patients are wanting today is a "healer" that sits and listens, demonstrates compassion and has the ability, the experience and the knowledge to help them get through that medical concern or emergency that has altered their lives at that moment. We may never get it right every time, but that is why we practice in collaborative environments where we ask for the help that we need.

I urge each of you to take a moment of reflection and consider your role as a clinician in your respective communities and consider how you may be perceived by your colleagues, by staff and by patients to ensure that your life and your profession expresses the person that you wish to be and not someone else. Remember we all have a sphere of influence in life and as medical professionals we have a responsibility to demonstrate the best that we can be as we care for others. And never forget... You CANNOT fake it.... till you make it!

HELMS Release 3: Enforcement+ on March 24, 2026

The Washington State Department of Health is excited to launch a new system for all healthcare professionals and facilities called HELMS (Health Enforcement and Licensing Management System). It brings applications and credentialing online with a modern, self-service user portal. This custom tool improves processing and provides a more secure, transparent experience.

The licensing and enforcement of health professionals and facilities is a critical part of the public health infrastructure. It is responsible for ensuring safe, high-quality, and accessible health care for all Washingtonians. HELMS supports the applications, processing, licensing, and enforcement of more than 560,000 professional and 12,000 facility credentials each year.

The HELMS team is excited to announce the final project release, Release 3: Enforcement+ (R3) on Tuesday, March 24, 2026.

Benefits of this release:

- Integration of enforcement functionality for health professionals and facilities
- Visual update to the public search tools
- Additional programs and features to complete the system

The primary users of the enforcement functionality of this release are providers or facilities responding to complaints or enforcement cases (respondents). Users can also submit complaints and track those complaints (complainants). All of these activities can be done through the HELMS user portal. Check out the video below for an overview of tools for respondents or refer to the instructions at these links:

- Respondent quick reference guide (PDF)
- Complainant user guide (PDF)

IMPORTANT TO KNOW

In the age where scammers are impersonating government officials at an alarming rate, we want to make sure that you are aware that communications from the Commission may look a little different with HELMS. System generated email will come from 'noreply@salesforce.com on behalf of <your WMC representative>'. Please follow the instructions in this email to view the secure communication.

Legal Actions

November 1, 2025 – January 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				
Grierson, James, MD MD00043397 Island County	Agreed Order of Reinstatement	11/14/25	Suspension of license in 2022 for sex with a patient and interference with the investigation.	License reinstated and placed on probation for one year and must disclose the Order to all patients prior to the first visit to include a copy of the order, a description of the sanctions, the DOH phone number and website; provide to DOH the employment name and address; and submit to compliance audits.
Janson, Vida J., MD MD00044016 King County	Final Order	1/23/26	Failure to comply with Commission order.	Indefinite suspension.
Kane, Sean, MD MD61108510 Whatcom County	Default Order	12/1/25	Inability to practice with reasonable skill and safety due to a health condition.	Indefinite suspension.
Kurup, Sunil R., MD MD61463487 Out of state	Automatic suspension of IMLC license	11/6/25	Suspension of license in Colorado.	Indefinite suspension.
Lee, Jane S.C., MD MD61506244 Out of state	Order of Summary Suspension	1/22/26	Surrender of license in California while under investigation.	Indefinite suspension.
Simon, Adam C., PA PA60240506 King County	Agreed Order	1/13/26	Sexual relationship with a patient.	Probation for at least one year; ethics course; fine; disclosure of order to patients; compliance audits.
Vega, Fernando D., MD MD00018929 King County	Order of Summary Suspension	1/7/26	Alleged failure to comply with Commission Order by treating a patient with Ibogaine, a Schedule I controlled substance.	Indefinite suspension.
Voegel-Podadera, Andrew M, MD MDRE.ML.61289341 King County	Agreed Order	12/18/25	Diversion of controlled substances for personal use.	Indefinite suspension; comply with WPHP contract. May petition for reinstatement in three years.

Informal Actions				
Practitioner Credential and County	**Order Type**	**Date**	**Cause of Action**	**WMC Action**
Brown, Tommy A., MD MD00042328 Pierce County	STID	1/15/26	Alleged making recommendations to family in private that were counter to the treatment plan previously agreed to by the care team, making the family fire the attending physician and disrupting the patient's care.	PROBE and PROBE plus programs; Course in professional communication; paper; personal appearances; costs; may petition to terminate in one year.
Chen, Jey-Hsin, MD MD60178931 King County	STID	11/20/25	Alleged disclosure of personal health information without consent of patients.	CME in confidentiality of personal health information; ethics course; paper; personal appearances; costs. May petition to terminate in one year.
Clemons, Jeffrey L., MD MD00031405 Skagit County	STID	11/20/25	Alleged inappropriate comment to patient during pelvic examination.	CME in patient centered care; review of topic of effective patient communication; paper; personal appearances; costs. May petition to terminate in one year.
Emer, Jason J., MD MD61328376 Out of state	STID	1/15/26	Disciplinary action in California.	Compliance with California order; costs. May petition to terminate when California order is terminated.
Garner, Frank A., MD MD00044148 Yakima County	STID	11/20/25	Alleged signing attestation of meeting CME requirements, but failure to produce documentation of completion of CME during an investigation.	Submit proof of completion of 200 hours of CME over previous four years; costs. May petition to terminate upon completion of requirements.
Haputa, Andrew J., MD MD00044349 Out of state	STID	11/20/25	Alleged licensing actions in Oregon and South Dakota, and DUI conviction in South Dakota.	Comply with WPHP health support agreement; personal appearances; costs. May petition to terminate upon completion of WPHP health support agreement.

Practitioner Credential and County	Order Type	Date	Cause of Action	WMC Action
Hosoda, Emitis K., MD MD00040765 Pierce County	STID	1/15/26	Alleged running of a wellness program while referring to herself as a "Dr." on the website and using the name of her medical practice in the wellness program materials causing a patient to believe Respondent would provide the treatment, and leading to a negative Google review and a request to remove the negative review.	CME in ethics, boundaries, and professionalism; paper; personal appearances; costs. May petition to terminate in two years.
Jensen, Frederick A., MD MD00028618 Thurston County	STID	11/20/25	Alleged failure to cooperate with investigation by failing to respond to investigator's letters during investigation.	Submit written response to investigator's letters; costs. May petition to terminate upon competition of requirements.
Kaufmann, Karl H., MD MD00038535 King County	STID	1/15/26	Alleged failure to order urinalysis and urine culture for infant with fever and high pulse rate in emergency department, diagnosing bronchitis when patient had sepsis.	CME in pediatric emergency medicine; paper; compliance audit; personal appearances; costs. May petition to terminate in two years.
Kowals, Daniel W., MD MD00043293 Lewis County	STID	11/20/25	Alleged failure to properly refer for evaluation five-day old infant who had lost 24% of weight since birth.	Submit newborn weight loss screening protocol for Commission approval; CME and either paper or peer group presentation on evaluating newborn growth and development; personal appearances; costs. May petition to terminate in one year.

Practitioner Credential and County	Order Type	Date	Cause of Action	WMC Action
Lin, Richard Lee-Tsong, MD MD60971388 King County	STID	11/20/25	Alleged prescribing of methotrexate to patients without documentation of clinical indications, or discussion of risks, benefits, and alternative treatments; prescribing to high-risk population without proper screening, pre-screening labs or follow-up monitoring; and advising patients to fill the prescriptions, but to dispose of the medication to satisfy an insurance requirement.	CME in ethics, prescribing, and documentation; paper; personal appearances; costs. May petition to terminate in one year.
Nyotowidjojo, Iwan S., MD MD61359497 Out of state	STID	1/15/26	Disciplinary action in California.	Restricted from practicing medicine in any manner and cannot renew or reactivate until Medical Board of California determines Respondent is safe to practice and fully restores Respondent's California license; costs. May petition to terminate after California license is fully restored.
Quimby, Jennifer C., MD MD00040782 Kitsap County	STID	1/15/26	Alleged mismanagement of obstetrical patient by not reviewing the fetal heart rate monitor until after patient had pushed for one hour, then starting Pitocin but not going to hospital to evaluate the patient until after five hours of labor and ten minutes before the baby was delivered.	CME in obstetrical care; paper; compliance audit; personal appearances; costs. May petition to terminate in three years.
Ridgway, James M., MD MD60074639 King County	STID	1/15/26	Alleged use of financial policy statement requiring patients to sign document that prohibited patients from posting negative online reviews.	Ethics course; paper; personal appearances; costs. May petition to terminate in two years.

Practitioner Credential and County	Order Type	Date	Cause of Action	WMC Action
Smith, Ray F., MD MD60648525 Clallam County	STID	1/15/26	Alleged increase of methadone dosage without documented rationale and failure to perform annual EKG for patient who died.	CME in record keeping and treatment of opioid use disorder; reflective paper on record keeping; scholarly paper on opioid use disorder; compliance audit; personal appearances; costs. May petition to terminate in three years.
Walters, Joseph J., MD MD60998938 Out of state	STID	1/16/26	Disciplinary action in California.	Probation; comply with California order; restriction against prescribing controlled substances for chronic pain, prescribing opioids to any patient for more than five days, treating patients for chronic pain, and supervising physician assistants and advanced practice nurses; supervision by a board-certified practitioner; personal appearances; costs. May petition to terminate when California order is terminated
Wilson, Lloyd P., MD MD60166731 Out of state	STID	1/15/26	Disciplinary action in Oregon.	Surrender of license.

Order of Summary Suspension: An order suspending a license prior to a hearing based on a determination that the licensee's continued practice represents a danger to the public.

Order of Summary Restriction: : An order restricting an aspect of a licensee's practice prior to a hearing based on a determination that the licensee's continued practice with an unrestricted license represents a danger to the public.

Agreed Order: a settlement resolving a statement of charges. This order is an agreement by a licensee to comply with certain terms and conditions to protect the public.

Final Order: an order issued after a formal hearing before the Commission.

Final Order on Default: an order issued after the licensee fails to respond to a statement of charges.

Final Order-Waiver of Hearing: an order issued after the licensee waives the right to a hearing on a statement of charges by the licensee to comply with certain terms and conditions to protect the public.

Stipulation to Informal Disposition (STID): a document detailing allegations, but with no findings or admissions, and containing an agreement by the licensee to comply with certain terms and conditions to protect the public.

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

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

Prepared to Lead Public Health Readiness

WASHINGTON Medical Commission

Licensing. Accountability. Leadership.

Mahlet Zeru, MPH - Strategy Manager

In January 2020, a patient with an unfamiliar respiratory illness arrived at a Washington State Urgent Clinic[1]. Within days, clinicians were confronting the nation's first confirmed case of COVID-19[2]. Guidance shifted rapidly[3]. Personal protective equipment was scarce[4]. Waiting rooms emptied as telehealth expanded almost overnight[5,6]. Hospital units were reorganized, and clinicians stepped into new roles while counseling anxious patients and families with limited information[7,8,9]. What began as a single case quickly became a statewide test of coordination and capacity management[10].

Moments like this define public health preparedness in Washington. Preparedness to respond when communities face emerging infectious threats, environmental crises, or catastrophic events[11]. Public health incidents, natural disasters, and manmade emergencies continue to challenge healthcare systems, reshape clinical practice, and expose vulnerabilities across public health infrastructure[12,13]. From the 2019 Clark County measles outbreak[14] to recurring wildfire smoke[15,16], the 2021 heat dome[17], hazardous material spills[18], radiological preparedness planning[19], and the possibility of a major earthquake along the Cascadia Subduction Zone[20], Washington's preparedness and recovery systems are repeatedly called into action.

As emergencies expand in scale, effective response depends on coordinated systems rather than individuals' effort. It requires structured coordination and deliberate planning[21]. Activation of the Incident Command System (ICS) organizes staff and resources into unified statewide response, aligning hospitals, public health authorities, and emergency management partners into shared operational objectives[22]. In Washington, collaboration with the Washington State Department of Health and local health jurisdictions through Emergency Support Function 8 (ESF-8) supports medical surge capacity, coordinated resource allocation, and supports implementation of crisis standards of care[23]. Understanding ICS and ESF-8 enables clinicians to connect bedside decisions with regional strategy and system-wide resilience[24].

Preparedness begins long before emergency systems are activated. The measles outbreak demonstrated that surveillance starts in the exam room[25]. Early recognition and timely reporting of notifiable conditions required under WAC 246-101 remain foundational to containment[26]. Clinicians can stay informed about emerging threats by monitoring Health Alert Network (HAN) notifications issued by the Washington State Department of Health[27]. These alerts enhance situational awareness by providing time-sensitive updates on emerging threats, exposure risks, testing guidance and mitigation strategies[28].

Preparedness extends beyond communicable disease surveillance to the environmental and infrastructure risks that shape Washington's regional threat landscape. Regional and environmental hazards further reinforce the need for vigilance[29]. Wildfire smoke predictably increases respiratory and cardiovascular morbidity[30], while the 2021 heat dome highlighted how quickly environmental conditions can strain emergency departments and disproportionately affect vulnerable populations[31]. Planning associated with facilities such as the Columbia Generating Station underscores readiness for low-frequency but high-impact scenarios[32]. In each case, preparedness translates into proactive patient counseling, participation in drills, and familiarity with emergency operations plans.

Equity must remain central to preparedness as public health emergencies consistently reveal and amplify existing health disparities[33]. COVID-19 and climate-related emergencies disproportionately affected communities of color, essential workers, tribal nations, individuals experiencing homelessness, and patients with limited English proficiency[34,35]. Structural barriers including limited access to healthcare, language services[36], transportation[37], and stable housing[38] can delay care and worsen outcomes during emergencies. Integrating equity into preparedness planning through culturally responsive communication, language access services, and inclusive response strategies helps ensure that mitigation surge response and recovery efforts reach those most at risk [39,40].

Emergencies will continue to test Washington's healthcare systems from infectious disease outbreaks to wildfire smoke to the possibility of a major seismic event. As that first COVID-19 case demonstrated, preparedness transforms uncertainty into coordinated action. Reviewing emergency operations plans, understanding ICS and ESF-8 activation processes, subscribing to HAN alerts, maintaining updated local health jurisdiction contacts, and engaging in disaster medicine education are practical steps that strengthen readiness. By integrating readiness into daily practice, MDs and PAs ensure the next crises is met with clarity and resilience.

WPHP Report

WPHP Marks 40 Years of Championing Physician Health

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

Vanessa Bloy, MSS
Communications Manager, Washington Physicians Health Program

For four decades, Washington Physicians Health Program (WPHP) has stood at the forefront of a simple but highly effective model that confidential help, not discipline, best supports a healthy and safe healthcare workforce. Founded on the belief that early intervention and compassion lead to better outcomes, WPHP has helped thousands of physicians and health professionals return to safe practice. As medical organizations face rising burnout, workforce shortages, and increasing complexity of care, WPHP's mission has never been more vital.

Physicians dedicate their careers to diagnosing and treating illness while navigating long hours, critical decisions, and the emotional weight of caring for others. When they experience physical health conditions, mental health challenges, or substance use disorders, the stakes are amplified — for their own well-being and for the patients who they serve. Yet many physicians and other health professionals delay or avoid seeking care due to legitimate concerns that disclosure could jeopardize their licenses or livelihoods. The cost of this silence is significant: untreated health conditions contribute to mental health crises, medical errors, workforce attrition, and burnout. In fact, national data indicates burnout rate among physicians is at 45%, with physicians being at higher risk for burnout relative to other US workers[1].

WPHP exists to provide a confidential pathway to address these concerns while safeguarding patient safety and preserving careers. WPHP is Washington's trusted resource for restoring the health of medical professionals. Our confidential support and exceptional outcomes provide reassurance of safe practice and promote workforce sustainability.

Reducing Physician Risk and Enhancing Patient Care

Early intervention is central to WPHP's impact. By identifying and addressing health concerns before they compromise clinical performance, WPHP supports physicians and health professionals in returning to safe practice. A study on physician health programs has shown that participants often exhibit lower rates of professional liability risk than non-participants and that patient care may be improved by PHP monitoring[2].

This data underscores not just the immediate benefits of WPHP participation, but its lasting value in helping health professionals recover health, sustain careers, and stay connected to the patients and communities they serve.

The value of a robust, advocacy-centered health program for health professionals cannot be overstated. Outcomes show that when physicians receive the right support at the right time, they can recover, thrive, and continue to provide the high-quality care that communities depend on. Throughout our four decades of service, WPHP has supported health professionals in Washington state with health support and ongoing advocacy that has helped them heal and continue practicing safely.

Physician Advocacy in Action

WPHP advocates at local and national levels for reforms that reduce barriers to accessing help while elevating the importance of improving professional satisfaction. These contributions further embed WPHP as a trusted partner in Washington's medical ecosystem. A prime example of this advocacy in action was our participation in the 2026 Washington State Medical Association Annual Legislative Summit at the Washington State Capitol in Olympia, where WPHP helped shape discussions about physician well-being and policy priorities at the state level.

WPHP also provided key testimony before the Washington Senate Health and Long-Term Care Committee in support of two pieces of legislation that will benefit license holders regulated by the Washington Medical Commission. The first bill was a technical remedy that will allow Anesthesiology Assistants to participate in WPHP through the implementation of a license surcharge that mirrors what other eligible professionals contribute.

The second bill provides license holders with a non-disciplinary pathway to relinquish their license. Relinquishment allows individuals who may be permanently unable to practice due to impairment or disability a dignified departure from practice that honors and respects their contribution to humanity.

One of WPHP's most significant recent achievements has been around credentialing reform. After several years of advocacy efforts, WPHP has helped successfully lead the Washington Credentialing Standardization Group (WCSG) in aligning the Washington Practitioner Application (WPA) with credentialing best practices as referenced in the American Medical Association article, "Teamwork Gives Washington State New Approach to Credentialing," by Tanya Albert Henry[3]. The WPA is the most commonly used credentialing application by health care systems in Washington. In 2023, the WPA was revised to ask only about current impairment rather than past diagnosis or treatment. The changes made earlier this year implemented updated model language to reduce the stigma surrounding healthcare professionals seeking mental and behavioral health care. By eliminating intrusive questions and fine-tuning question wording, a major barrier to physician well-being has been removed.

WPHP extends gratitude to Makrina Shanbour, MD, Director of Provider Experience at Confluence Health, and her team for their partnership, as well as to Carrianne Dockter, Chair of the WCSG, for her steadfast leadership throughout the reform process.

Expanding Education and Awareness

To further elevate awareness of WPHP's program and services and how we help support the healthcare community across Washington state, we recently produced a one-hour educational presentation entitled "WPHP Overview & Impairment." We encourage all health professionals to watch it to learn how:

- Impairment is defined and how it applies to health professionals including the ethical and legal obligations for responding to concerns of impairment.
- Signs of impairment in health professionals and barriers to effectively addressing concerns of impairment.
- The process by which WPHP assists health professionals with concerns of impairment and the basis for effective advocacy that balances public trust and the need to protect patient safety with the rehabilitative needs of health professionals.
- Outcomes that demonstrate WPHP's effectiveness and benefits of program participation.

As healthcare challenges evolve, WPHP's leadership in physician health, advocacy, and policy reform, ensures that Washington's health professionals, along with the patients they serve, are supported for decades to come. If you or a colleague need help, please do not hesitate to contact WPHP at wphp.org or 800-552-7236.

References

1. Changes in Burnout and Satisfaction With Work–Life Integration in Physicians and the General US Working Population Between 2011 and 2023. Shanafelt, Tait D. et al. Mayo Clinic Proceedings, Volume 100, Issue 7, 1142–1158. DOI: 10.1016/j.mayocp.2024.11.031
2. Brooks E, Gendel MH, Gundersen DC, et al . Physician health programmes and malpractice claims: reducing risk through monitoring. Occup Med (Lond). Jun 2013;63(4):274-80. doi:10.1093/occmed/kqt036
3. Henry, Tanya Albert. "Teamwork Gives Washington State New Approach to Credentialing." American Medical Association, 26 Jan. 2026, https://www.ama-assn.org/practice-management/physician-health/teamwork-gives-washington-state-new-approach-credentialing.

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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.

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 that participating providers are informed and regulated by current national industry and best practice standards.

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

Upcoming 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 246918171 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.

Upcoming Events

April - 2026

- 13 - Rules Workshop Chapter 246-919 WAC, Allopathic Physicians
- 27 - Opioid Prescribing General Provisions for MDs and PAs

May - 2026

- 07 - Personal Appearances
- 08 - WMC Business Meeting
- 08 - WMC Lunch & Learn- Topic TBA
- 25 - Memorial Day- WMC Offices Closed

June - 2026

- 01 - Opioid Prescribing General Provisions for MDs and PAs
- 15 - Rules Workshop Chapter 246-919 WAC, Allopathic Physicians
- 19 - Juneteenth- WMC Offices Closed
- 25 - Policy: Interested Parties

July - 2026

- 03 - WMC Offices Closed in Observance of Independence Day
- 09 - Personal Appearances
- 13 - Opioid Prescribing General Provisions for MDs and PA
- 23 - Policy Committee
- 27 - Chapter 246-919 WAC, Allopathic Physicians

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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.

1 Holshue, M. L., DeBolt, C., Lindquist, S., Lofy, K. H., Wiesman, J., Bruce, H., Spitters, C., Ericson, K., Wilkerson, S., Tural, A., Diaz, G., Cohn, A., Fox, L., Patel, A., Gerber, S. I., Kim, L., Tong, S., Lu, X., Lindstrom, S., Pallansch, M. A., … Washington State 2019-nCoV Case Investigation Team (2020). First Case of 2019 Novel Coronavirus in the United States. The New England journal of medicine, 382(10), 929–936. https://doi.org/10.1056/NEJMoa2001191

2 Holshue, M. L., DeBolt, C., Lindquist, S., Lofy, K. H., Wiesman, J., Bruce, H., Spitters, C., Ericson, K., Wilkerson, S., Tural, A., Diaz, G., Cohn, A., Fox, L., Patel, A., Gerber, S. I., Kim, L., Tong, S., Lu, X., Lindstrom, S., Pallansch, M. A., … Washington State 2019-nCoV Case Investigation Team (2020). First Case of 2019 Novel Coronavirus in the United States. The New England journal of medicine, 382(10), 929–936. https://doi.org/10.1056/NEJMoa2001191

3 Knutsen Glette, M., Ludlow, K., Wiig, S., Bates, D. W., & Austin, E. E. (2023). Resilience perspective on healthcare professionals' adaptations to changes and challenges resulting from the COVID-19 pandemic: a meta-synthesis. BMJ open, 13(9), e071828. https://doi.org/10.1136/bmjopen-2023-071828

4 Bauchner, H., Fontanarosa, P. B., & Livingston, E. H. (2020). Conserving Supply of Personal Protective Equipment-A Call for Ideas. JAMA, 323(19), 1911. https://doi.org/10.1001/jama.2020.4770

5 Centers for Medicare & Medicaid Services (2020) Additional Background:Sweeping Regulatory Changes to Help U.S. Healthcare System Address COVID-19 Patient Surge | CMS

6 Shaver J. (2022). The State of Telehealth Before and After the COVID-19 Pandemic. Primary care, 49(4), 517–530. https://doi.org/10.1016/j.pop.2022.04.002

7 Bessis, S., Dinh, A., Gautier, S., Davido, B., Levy, J., Lawrence, C., Lot, A. S., Bensmail, D., Rech, C., Farcy-Afif, M., Bouchand, F., de Truchis, P., Herrmann, J. L., Barbot, F., Orlikowski, D., Moine, P., Perronne, C., Josseran, L., Prigent, H., & Annane, D. (2022). A Restructured Hospital Into a One-Building Organization for COVID-19 Patients: A Resilient and Effective Response to the Pandemic. Frontiers in public health, 10, 709848. https://doi.org/10.3389/fpubh.2022.709848

8 Ribeiro, C. R., Haddad, M. D. C. F. L., Oussaki, F. M. D. S., Bolorino, N., Radovanovic, C. A. T., Barreto, M. F. C., & Dadalt, P. A. (2025). Hospital reorganization at a public university hospital to address the COVID-19 pandemic. Revista brasileira de enfermagem, 78(3), e20240281. https://doi.org/10.1590/0034-7167-2024-0281

9 Jeffs, L., Limoges, J., Das Gupta, T., Di Prospero, L., Harris, A., Merkley, J., Rosen, B., Reid, M., Rao, M., Black, A., Zeng, R. L., & McGillis Hall, L. (2025). How did staffing strategies change amid COVID-19 and post pandemic? A qualitative study. BMJ open, 15(6), e091922. https://doi.org/10.1136/bmjopen-2024-091922

10 McLaughlin, H. P., Hiatt, B. C., Russell, D., Carlson, C. M., Jacobs, J. R., Perez-Osorio, A. C., Holshue, M. L., Choi, S. W., & Gautom, R. K. (2021). COVID-19 Response Efforts of Washington State Public Health Laboratory: Lessons Learned. American journal of public health, 111(5), 867–875. https://doi.org/10.2105/AJPH.2021.306212

11 Khatri, R. B., Endalamaw, A., Erku, D., Wolka, E., Nigatu, F., Zewdie, A., & Assefa, Y. (2023). Preparedness, impacts, and responses of public health emergencies towards health security: qualitative synthesis of evidence. Archives of public health = Archives belges de sante publique, 81(1), 208. https://doi.org/10.1186/s13690-023-01223-y

12 Fridell, M., Edwin, S., von Schreeb, J., & Saulnier, D. D. (2020). Health System Resilience: What Are We Talking About? A Scoping Review Mapping Characteristics and Keywords. International journal of health policy and management, 9(1), 6–16. https://doi.org/10.15171/ijhpm.2019.71

13 Makwana N. (2020). Public health care system's preparedness to combat epidemics after natural disasters. Journal of family medicine and primary care, 9(10), 5107–5112. https://doi.org/10.4103/jfmpc.jfmpc_895_19

14 Carlson, A., Riethman, M., Gastañaduy, P., Lee, A., Leung, J., Holshue, M., DeBolt, C., & Melnick, A. (2019). Notes from the Field: Community Outbreak of Measles - Clark County, Washington, 2018-2019. MMWR. Morbidity and mortality weekly report, 68(19), 446–447. https://doi.org/10.15585/mmwr.mm6819a5

15 Washington State Department of Ecology (2017) Exceptional Event Demonstration for September 2017 PM10 Exceedances Due to Wildfires Publication 19-02-004 2017 Final

16 Doubleday, A., Schulte, J., Sheppard, L., Kadlec, M., Dhammapala, R., Fox, J., & Busch Isaksen, T. (2020). Mortality associated with wildfire smoke exposure in Washington state, 2006-2017: a case-crossover study. Environmental health : a global access science source, 19(1), 4. https://doi.org/10.1186/s12940-020-0559-2

17 USDA Northwest Climate Hubs 2021 Northwest Heat Dome: Causes, Impacts and Future Outlook | USDA Climate Hubs

18 Spill incidents - Washington State Department of Ecology

19 Radiological Emergency Preparedness | Washington State Department of Health

20 Cascadia Subduction Zone Earthquake and Tsunami Response Plan

21 Comprehensive Integrated Preparedness Plan 2025-2029

22 Furin M, Freeman CL, Goldstein S. EMS Incident Command System. (2024). https://www.ncbi.nlm.nih.gov/books/NBK441863/
23 WA_CEMP_ESF8_Appendix 3 Fatality Management Incident Support
24 Comprehensive Integrated Preparedness Plan 2025-2029
25 Carlson, A., Riethman, M., Gastañaduy, P., Lee, A., Leung, J., Holshue, M., DeBolt, C., & Melnick, A. (2019). Notes from the Field: Community Outbreak of Measles - Clark County, Washington, 2018-2019. MMWR. Morbidity and mortality weekly report, 68(19), 446–447. https://doi.org/10.15585/mmwr.mm6819a5
26 WAC Notifiable Conditions Chapter 246-101 WAC:
27 Health Alert Network (HAN) | HAN | CDC
28 Health Alert Network (HAN) | HAN | CDC
29 Environmental Assessment - Washington State Department of Ecology
30 Aguilera, R., Letellier, N., Basu, R., Vaidyanathan, A., Casey, J. A., Gershunov, A., Diao, M., & Benmarhnia, T. (2025). Effects of Multiple Wildfire Smoke Pollutants ($PM_{2.5}$, PM10, and Ozone) on Respiratory and Cardiovascular Hospitalizations in California (2006-2019). GeoHealth, 9(12), e2025GH001510. https://doi.org/10.1029/2025GH001510
31 Wettstein, Z. S., Hall, J., Buck, C., Mitchell, S. H., & Hess, J. J. (2024). Impacts of the 2021 heat dome on emergency department visits, hospitalizations, and health system operations in three hospitals in Seattle, Washington. Journal of the American College of Emergency Physicians open, 5(1), e13098. https://doi.org/10.1002/emp2.13098
32 franklin county COLUMBIA GENERATING STATION EMERGENCY PReparedness PLAN
33 Conduah, A. K., & Ofoe, S. H. (2025). Intersecting impacts of ageing, migration, and socioeconomic disparities on health equity: a post-pandemic policy review. International journal for equity in health, 24(1), 304. https://doi.org/10.1186/s12939-025-02683-0
34 Khan, S. U., Hagan, K. K., & Javed, Z. (2022). Disproportionate Impact of COVID-19 Among Socially Vulnerable Patients. Circulation. Cardiovascular quality and outcomes, 15(8), e009294. https://doi.org/10.1161/CIRCOUTCOMES.122.009294
35 Khan, S. U., Hagan, K. K., & Javed, Z. (2022). Disproportionate Impact of COVID-19 Among Socially Vulnerable Patients. Circulation. Cardiovascular quality and outcomes, 15(8), e009294. https://doi.org/10.1161/CIRCOUTCOMES.122.009294
36 Al Shamsi, H., Almutairi, A. G., Al Mashrafi, S., & Al Kalbani, T. (2020). Implications of Language Barriers for Healthcare: A Systematic Review. Oman medical journal, 35(2), e122. https://doi.org/10.5001/omj.2020.40
37 Syed, S. T., Gerber, B. S., & Sharp, L. K. (2013). Traveling towards disease: transportation barriers to health care access. Journal of community health, 38(5), 976–993. https://doi.org/10.1007/s10900-013-9681-1
38 Calloo, G. V., Odei Boateng, M., Agbe, E. A., & Boateng, G. O. (2026). Shelter to Survival: Unpacking the Health Impacts of Housing Insecurity Across the Life Course. International journal of environmental research and public health, 23(1), 91. https://doi.org/10.3390/ijerph23010091
39 Casillas, A., Flores-Uribe, E., Abhat, A., Moreno, G., Brown, A., Szilagyi, P. G., & Norris, K. (2022). The language of COVID-19: Health systems must now prioritize responsive in-language and culturally-tailored messaging. International journal of disaster risk reduction : IJDRR, 77, 103077. https://doi.org/1 0.1016/j.ijdrr.2022.103077
40 Ortega, P., Martínez, G., & Diamond, L. (2020). Language and Health Equity during COVID-19: Lessons and Opportunities. Journal of health care for the poor and underserved, 31(4), 1530–1535. https://doi.org/10.1353/hpu.2020.0114