UPDATE!

Washington Medical Commission Vol. 10, Spring 2020

Message From The Chair: Musings on Peer Review

Alden Roberts, MD, MMM, FACS

A 28 year old mother of three presented to the ED of an excellent WA hospital one weekend, a few days following a difficult GYN procedure. Her complaint was abdominal pain, and she was hypotensive and tachycardic. The ED physician diagnosed her as septic, and the on-call GYN was consulted (the operating surgeon was not available). The GYN assessed the patient and asked for a general surgery consult. Surgery suggested that GYN needed to resuscitate the patient in the ICU and to call back if necessary. The patient was admitted to the ICU and a pulmonary/intensivist was asked to see the patient. The intensivist suggested that the hospitalist could manage the sepsis. The hospitalist started fluids and antibiotics and left a message for the infectious disease consultant to see the patient in the morning. ID saw the patient and stated in their progress note that the sepsis was most likely of surgical origin, but there was no direct communication between providers. When the GYN made rounds, they were reassured that the patient seemed somewhat better with fluids and antibiotics, and didn't call general surgery back. Late that evening, the patient crashed and the intensivist was called again. The intensivist intubated and resuscitated the patient, and in the early morning hours again called general surgery. It was agreed that general surgery would see the patient first thing that morning. The general surgeon came in early to see the patient, but also saw a patient with acute appendicitis. They put the patient with acute appendicitis on first because that procedure would be quick. Nearly two days after admission and prior to beginning her surgery, the 28 year old wife and mother of three suffered a cardiac arrest from which she could not be resuscitated. Autopsy revealed a perforated viscus from the original procedure with the resultant sepsis as the cause of death. This case was reviewed by each department at their departmental peer review. It took more than a year for this case to make it through four separate departmental peer reviews, and each department concluded that

Yet the death of this young woman was avoidable, and any one of her very competent and well-meaning physicians could have orchestrated a different outcome

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WMC Mission

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

the physician in their department did everything right, but that the other departments could have done a better job. Yet the death of this young woman was avoidable, and any one of her very competent and well-meaning physicians could have orchestrated a different outcome.

No one likes to have a case reviewed, and we like it even less if we are told that we could potentially have done better; yet that is the function of peer review and is an important mechanism for improving the care we provide our patients. The act of requiring us to consider whether or not we could have provided better management is of value by itself, because physicians and PAs tend to be very self-motivated - if we can avoid being too defensive.

Unfortunately, there is a lot of room for improvement in the peer review process. Peer review requires time and preparation to be effective. Often, physicians with little time and less interest are being asked to do this complex job, with inadequate infrastructure and support staff, for little or no reimbursement. Peer review at most places is done as it has been for the last 50 years: by individual departments. But there are a number of problems with departmental peer review. First, current medical care is provided by a multidisciplinary team, and system issues that set up medical errors and poor outcomes are not in the control of individual departments. Second, departmental peer review is rarely timely, and memories of an event change with time. Third, departmental peer review is caught between specialty bias, which tends to excuse problems within a specialty and competitive bias. Bias tends to exaggerate problems of competitors, and lack of anonymity of the reviewer, which interferes with the performance of an impartial review.

As in the case presented at the beginning of this article*, the vast majority of significant patient care problems occur with good physicians doing the best they can. Ideally, the goal of peer review should be patient centered physician accountability, with continuous improvement through honest self-reflection and appropriate education.

**The case presented is a fictional case. It is presented as a base to consider the importance of good peer review*

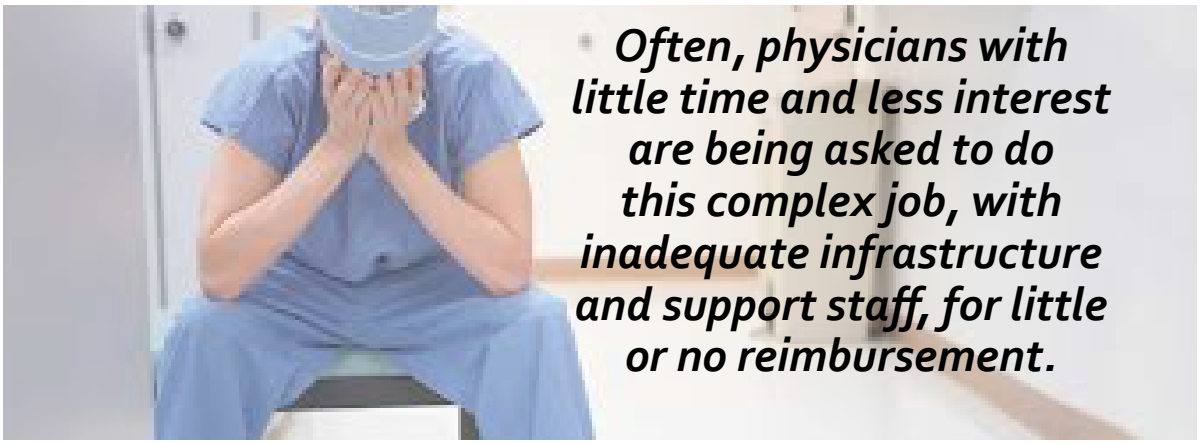
This requires certain core principles:

1. Peer review proceedings should be protected from legal discovery.
2. Peer review should be multidisciplinary if possible, with ready access to unbiased specialty assessment.
3. Reviewer anonymity is critical in order to facilitate an impartial and honest review.
4. The process should be objective, reproducible, transparent and timely.
5. The outcome should be non-punitive and educational for the physician being reviewed, and exceptional work should be recognized as well.
6. The process should have the ability to identify and to facilitate the correction of system issues.
7. There should be clear separation between the peer review function and departmental disciplinary responsibilities.

The principles of just culture and highly reliable organization theory have been used by national professional organizations to establish what "best practice" for peer review ought to look like. While the process chosen should be developed by the physicians who will be undergoing peer review, it isn't necessary to reinvent the wheel. Help is available for those who want to develop a truly effective peer review process.

Much of what comes to WMC attention would have been much better managed by a high quality, local peer review process. The WMC does occasionally see that there are some organizations in Washington State who are doing an excellent job with peer review. The WMC can consider in its evaluation of a complaint what a respondent has already done to address the alleged issues. If the WMC finds that everything that would have been required through a disciplinary action has already been accomplished by the respondent, it may find that no disciplinary action is needed.

Peer review is one of the best ways to improve patient safety, but it requires physician leadership. It also requires monetary support necessary to provide adequate infrastructure, including staff support. Physicians and PAs with an interest and energy to invest the time can truly improve patient care by working on high functioning peer review processes.



Executive Director Report: COVID-19 Impact

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

Melanie de Leon, JD, MPA
Executive Director

COVID-19 has changed the way we go about our daily lives and especially how we accomplish our work. Under Department of Health (DOH) guidance, the Medical Commission (WMC) has altered their work patterns and those alterations may impact you. We are trying our best to provide world class customer service, but there are steps we have had to take that make it *not* business as usual. Here is some information that I hope you find helpful as we work through the next few months:

Staffing. All staff who can work from home are doing so. As of March 16 at 10am, that left one staffer in the office with four others rotating in on alternate half-days. Everyone else is teleworking full-time. We have, for the most part, electronic process that allow us to do that. However, not all staff have access to work-provided cell phones, so contacting us is best done through e-mail.

Licensing. Staff are teleworking although our current processes are still very much paper-centric, so this new work environment may impact licensing timelines. We are trying very hard to be as responsive as possible. E-mail is the best option for contacting Licensing during the next few weeks.

Commission meetings. Our April business meeting is cancelled and rules workshops have now become virtual meetings. Our website contains call-in information should you want to attend virtually. We are discussing our May meeting options based upon the Governor's guidance to limit meetings. We have never held a virtual business meeting, so we are trekking through uncharted territory here and I have no definitive information at this time.

While we work through this, we need your help finding and activating emergency volunteer health practitioners in preparation for health system requests and surging. This will help the state meet emerging demands for healthcare workers.

The DOH can perform this work under the authority of the Uniform Emergency Volunteer Health Practitioner Act (chapter 70.15 RCW), if an emergency proclamation by the Governor is in effect - as is the case in Washington as of Feb. 29, 2020.

If volunteers are registered in the volunteer health practitioner system and verified to be in good standing in all states where they are licensed, they may practice in Washington without obtaining a Washington license once activated and assigned by DOH.

In-state practitioners can become volunteers in two ways:

- Via RCW chapter 70.15 by registering and completing the Emergency Volunteer Health Practitioners Application which can be found here
- Via registering with their local Medical Reserve Corps; more information can be found here.

Out-of-state practitioners may:

- Become volunteers via RCW chapter 70.15 by registering and completing the **Emergency Volunteer Health Practitioners Application** which can be found here
- Out of state MDs and DOs that would like an expedited Washington license and to volunteer, may use the Interstate Medical License Compact and become registered under RCW 70.15. At this time, we are limiting our request for health care practitioners to U.S. jurisdictions due to technical issues. We may expand the call to international jurisdictions in the future as needs arise, and if that remains available to us based on federal restrictions.

Applications will be screened by the DOH to ensure the potential volunteer's health license is in good standing in each state where they are licensed. The DOH will activate, deploy and deactivate approved volunteer health practitioners as needs are identified and requested. Please share this urgent request broadly.

Online Delegation Agreements Are Now Available

Completing the new online form for delegation agreements will allow PAs same-day provisional approval to practice. Access the free online form here.

WPHP Report: Setting the Record Straight, Part 3

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

Introduction
In this, the final installment in this series, we continue our journey toward a deeper understanding of what your physician health program is, what it does and why. As previously mentioned, part of WPHP's mission is to inform and educate the medical community about physician health and impairment. In so doing, we facilitate informed decision-making and demonstrate accountability to those we serve. One of the areas of our work that is often misunderstood is the evaluation and treatment process, particularly with respect to concerns related to substance use. In what follows, I will address some of the common questions and nuances about the evaluation and treatment process as well as the outcomes that support our model.

Does WPHP provide treatment?
No. WPHP provides case management and referral for evaluation and treatment based on an initial assessment conducted by our clinical staff. This assessment includes an extensive biopsychosocial history, toxicology testing and cognitive screening. In addition, we engage in a detailed review of the concerns that led to the WPHP referral and the health professional's understanding of those circumstances. We then integrate all the available data into a clinical formulation that serves as the basis for next steps. Often, we identify illness or distress but no evidence of impairment or risk of impairment. In such cases we can offer support, referral for treatment and other resources without the need for ongoing monitoring. However, if we believe the individual is impaired (unable to practice with reasonable skill and safety due to a health condition) or at significant risk for impairment we may recommend a comprehensive diagnostic evaluation (CDE) at a center with special expertise in the assessment of physicians and other safety sensitive workers. Independent third-party evaluation and treatment helps ensure an objective and accurate appraisal of the individual's health and safety to practice.

How does WPHP select evaluation and treatment centers?
WPHP approves the evaluation and treatment centers that provide CDEs and multidisciplinary treatment based on criteria set forth the in the Federation of State Physician Health Program Guidelines (1), the Federation of State Medical Boards Policy on Physician Impairment (2) and our Department of Health contract. It is well known that physicians and other health professionals require specialized evaluation and treatment services tailored to the unique manifestations of illness, response to treatment, and professional re-entry characteristics of this population (3). It is critical that these programs have substantial experience and expertise in the evaluation and treatment of health professionals, specific programming unique to their needs and, in treatment settings, a cohort of health professional peers. In addition, these programs must have the developed expertise to evaluate a health professional's fitness for practice and provide return to practice plans that are informed by a thorough understanding of the professional's health condition and job-specific work demands.

How accessible is this specialized care?
Unfortunately, there are a limited number of programs across the country that meet our rigorous approval criteria, and none are currently located in Washington. In addition, the higher level of treatment intensity and duration required to facilitate an expedient and safe return to practice may not be adequately covered by health insurance, thus increasing the self-pay burden to physicians. This is almost always a source of distress for our participants. It is therefore not surprising that participants often lobby for local treatment from providers of their choosing covered by their health insurance. However, experience has shown that compromising the quality of evaluation and treatment in the interest of cost, convenience or participant preference can result in poor or even devastating personal and professional outcomes while also undermining the credibility of WPHP advocacy upon which our participants rely. While relapse or recurrence may be expected in the recovery process, health care employers, credentialing entities and the public are, understandably, less tolerant of such in physicians and other health professionals. It is therefore imperative that WPHP follow established guidelines that are designed to promote the best outcomes for physicians and the public.

When our peers get sick, they deserve the best care and opportunity for rehabilitation and return to work available. WPHP tirelessly advocates with payors and providers to mitigate out of pocket care expenses for our participants. In addition, we provide need-based scholarships, funded from charitable donations, to assist with evaluation and treatment expenses. Through these efforts, we have been very successful in helping our participants overcome financial barriers to appropriate care.

How does WPHP protect against bias in the evaluation process?
Conflict of interest in the evaluation process has typically centered on two concerns. The first is a misguided idea that PHPs somehow receive financial benefit from the evaluation and treatment centers they use. As stated in Part 1 of this series, WPHP has strict conflict of interest policies that prohibit us from accepting any material benefit from an organization or entity with a business interest in WPHP. We strongly believe that, in no case, should there be a financial or business interest between a PHP and approved evaluation or treatment providers.

The second concern involves the idea that conflict of interest is inherent when evaluators also serve as treatment providers. This situation is neither unique nor discouraged in the orthodoxy of the medical profession, where it is customary to provide both diagnostic and treatment services. That said, because of the potential professional implications involved in these evaluations, WPHP takes several measures to mitigate actual or perceived conflicts. WPHP informs participants when evaluators also provide treatment, provides participants with a choice of several approved evaluators, advises participants that they may inform their evaluator that they intend to pursue treatment elsewhere if treatment is recommended and directs evaluators to recuse themselves from offering treatment if the participant raises concerns about conflict of interest.

What outcomes can a doctor or PA expect by participating in the program?
WPHP assesses program performance and develops program improvements through systematic collection and analysis of clinical data and participant surveys. Numerous quality, satisfaction and outcome variables are measured and compared to internal and external benchmarks.

More than 90% of WPHP participants are working in their field at program completion with 87% having their medical license in good standing without restriction and 75% reporting benefit from WPHP advocacy. Among substance use disorder (SUD) participants, 80% have no relapse to active use during the 5-year monitoring period and, among those that relapse, two-thirds have a single brief episode. These outcomes are typical of PHPs (4), have been stable over time (5) and are unrivaled in the field of addiction medicine. It is more challenging to define and categorize relapse or recurrence for non-substance related conditions, so we don't have systematic data on these outcomes. However, our experience and research (6) suggest outcomes are comparable to those achieved by our SUD participants.

96% of participants rate their overall health as good or higher at program completion with two-thirds of that group rating their health as very good or excellent. WPHP participants consistently experience less than half the rate of burnout reported in national samples with only 15% reporting significant symptoms of burnout in 2019. At program completion, 80% report improved personal relationships and better work-life balance that they attribute directly to program participation. In short, the benefits of program participation extend beyond management of the impairing health condition. For a more detailed review of these benefits please see our WPHP 2019 Annual Report.

Program participants report high levels of satisfaction. Over the past four years, 60-80% participants have rated their overall program satisfaction at six points or higher on a seven-point Likert scale. We have received similar satisfaction ratings from Chief Medical Officers and Graduate Medical Education Program Directors. At program completion, 80% of participants rate the program as "extremely useful" or "lifesaving" on anonymous exit surveys and 95% report being treated with courtesy, respect and professionalism by WPHP staff.

Finally, and perhaps most importantly; suicide appears to be rare among WPHP participants. Over the past 10 years, there have been three WPHP program participants who died from suicide. Due to incomplete data and low base rate issues in studying suicide, we can't know for sure whether the relative risk for suicide among WPHP program participants is higher or lower than non-participant health professionals in Washington. However, we do know that WPHP participants have risk factors for suicide that place them at the highest levels of risk among an already high-risk group (physicians are 1.5-3.5 times more likely to die by suicide than the general population). Although physician suicide statistics for Washington are not known, suicide rates among physicians nationally allow us to estimate that at least 100 physician suicides likely occurred in our state during the past decade. This means that the vast majority of physician suicides (known and unknown) in Washington occurred outside of our program. That so few suicides have occurred among WPHP participants, who are arguably among the highest risk for suicide among physicians and PA's in Washington, suggests that involvement in WPHP may be protective against suicide, especially considering that we intervene on the very factors that most contribute to elevated risk. I have personally had dozens of participants tell me that WPHP saved their life and that they had been on the brink of suicide or made a suicide attempt prior to coming into our program. I often wonder how many deaths from suicide might have been prevented had the physician or PA found WPHP first.

Conclusion
It is my sincere hope that this series has shed light on the work we do and how it benefits our colleagues, patients and the profession. Threading the needle of rehabilitation and advocacy for our participants while protecting public safety is a complex and often daunting endeavor. The

challenges and rewards of this work fuel the passion and commitment required so that our participants may flourish. I will unapologetically confess that I am most certainly biased. As a former WPHP participant myself, I offer my own testimonial as to the merits of this program, an unequivocal endorsement that is rooted in personal experience. And while I have tried to focus on clear and accurate data in describing our program so that readers might arrive at their own conclusions, it is difficult to interpret the words of this series without the benefit of context. In the end, it is our participants and alumni themselves who provide that context – it is their voices and stories that bring hope and meaning to the information that this series has provided. To hear from them, learn more about our program and stay up to date on issues in physician health, please visit us at our recently updated website and/or follow us on Facebook and LinkedIn. We look forward to continuing this journey with you!

References

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Billing hepatitis C medications for Apple Health clients

From Health Care Authority

All hepatitis C (HCV) medications are paid for by the Apple Health (Medicaid) fee-for-service (FFS) program. Mavyret does not require prior authorization (PA). All other HCV medications require PA. For coverage criteria please see the Antivirals - Hepatitis C Treatment policy.

To bill FFS for an HCV medication prescribed to a client enrolled in an Apple Health Managed Care Plan, include a "2" in the Claim Segment, Prior Authorization Type Code (461-EU) field. All FFS rules apply, including authorization requirements.

If a pharmacy claim for an HCV medication is billed to an Apple Health Managed Care Plan, you will receive the following rejection message:

Apple Health Managed Care Plan	Message Line 1	Message Line 2
Amerigroup	Product Service ID Carve-Out Bill Medicaid Fee for Service.	Excluded NDC, Bill WA FFS BIN 610706 Plan Exclusion
Community Health Plan	Product/services not covered	Bill HCA FFS- Call 800-562-3022
Coordinated Care	Bill to Health Care Authority	Contact HCA at 800-562-3022. Plan Exclusion.
Molina	831 Bill Medicaid FFS	Plan Exclusion bill to Provider One
United Health	Bill Fee For Service	

For questions, please e-mail us.

Rulemaking Efforts

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Amelia Boyd

Program Manager

Chapter 246-919 WAC
The CR-101 for Chapter 246-919 WAC was filed with the Office of the Code Reviser on January 2, 2018 as WSR #18-02-079.

The WMC is considering updating the chapter to more closely align with current industry standards and provide clearer rules language for licensed allopathic physicians. In addition, RCW 43.70.041 requires the WMC to review its administrative rules every five years to ensure that regulations are current and relevant.

Rule amendments being considered will potentially benefit the public's health by ensuring participating providers are informed and regulated by current national industry and best practice standards.

On July 12, 2019 the WMC approved initiating the next step in the rulemaking process, Proposed Rule Making (CR-102).

Clinical Support Program
The CR-101 for WAC 246-919-XXX Physicians and WAC 246-918-XXX Physician Assistants was filed with the Office of the Code Reviser on February 22, 2018 as WSR #18-06-007.

The WMC is considering creating two new rule sections, and revising related rule sections as appropriate, to establish a clinical support program (program), its criteria and procedures for allopathic physicians and physician assistants. The intent of the program is to assist practitioners with practice deficiencies related to consistent standards of practice and establish continuing competency mechanisms that will protect patients proactively through a plan of education, training and/or supervision. The WMC may resolve practice deficiencies through the program at any point in a practitioner's period of licensure.

The program would allow for quick identification of issues requiring clinical support, through practitioner or employer inquiry, referral, and including complaints that may not rise to the level of a license sanction or revocation. These issues could be resolved with voluntary participation from the allopathic physician or physician assistant in the program. The WMC is considering education, training, supervision, or a combination of the three as part of the program. Issues appropriate for clinical support would likely include but are not limited to practice deficiencies such as a failure to properly conduct a patient assessment or document treatment. This also allows an allopathic physician or physician assistant a structured process to quickly improve his or her clinical skills.

Finally, participation in this program places the WMC in an active patient safety role.

At their business meeting on November 15, 2019, the WMC approved initiating the next step in the rulemaking process, Proposed Rule Making (CR-102).

Telemedicine
The CR-101 for Telemedicine was filed with the Office of the Code Reviser on September 17, 2019 as WSR #19-19-072.

The WMC will consider rulemaking to address the practice of physicians and physician assistants engaging in telemedicine with Washington patients. Possible subjects the WMC may address are: What, if any requirements for licensure; recordkeeping requirements; establishing a patient-practitioner relationship; prescribing issues; and standard of care. Regulating the use of telemedicine would place the WMC in an active patient safety role.

Substitute Senate Bill 5380 – Concerning opioid use disorder treatment, prevention, and related services.
Substitute Senate Bill (SSB) 5380 was passed by the legislature on April 16, 2019. The bill is concerning opioid use disorder treatment, prevention, and related services and mandates that the WMC adopt rules for both allopathic physicians and physician assistants. A rules hearing was held on December 12, 2019 where the draft language was adopted. The rules will become effective February 29, 2020.

For more information about these rules, please visit our website.

More Information
Please visit our rulemaking site.

For continued updates on rule development, interested parties are encouraged to join the WMC's rules GovDelivery.

PA News: Presenteeism

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Jim Anderson PA-C, MPAS, DFAAPA
Physician Assistant Member

In the quickly changing COVID-world we live in, there are many strains on medical providers. And one of the strains, both now and in the past, is deciding when to go to work when not feeling well.

In a recent issue of STAT, one of my favorite medical blogs, medical ethicist MD Steven Joffe wrote a piece entitled "Working while sick is bad enough in ordinary times. During the Covid-19 outbreak it could be catastrophic." The compelling post posits something that's been stuck in my craw for years; our medical systems actually incentivize medical providers to work while sick. And as Jaffe notes, "It's bad enough in ordinary times for a doctor or nurse to work while sick. But as Covid-19 hits hospitals, as it almost certainly will, the tendency of health care professionals to work through illness will present a serious threat to both patient safety and the public's health."

Our medical systems actually incentivize medical providers to work while sick.

It's called "presenteeism," a concept that has been discussed for many years, and it appears to be pervasive. There's much literature looking at this cause of decreased productivity in the medical world, but Joffe offers a look instead at the flaws in our medical system that drive sick providers to work, and the dangers this poses to patients. Jaffe notes that while the temptation is to blame providers for this problem, the true culprit is a flawed medical system.

This piece notes data showing that about half of all surveyed hospitals lacked policies about screening ill workers, as well as lacking effective systems for backing up sick providers who need to stay home. Jaffe also cites data indicating that medical staff, including PA and NPs, come to work sick because of fears of adding stress to their co-workers, as well as worries about abandoning their patients.

Something I've observed in my career as a PA is financial incentivization for staff to come to work sick. While working in a major children's medical center, I was stunned to see this in action. The medical center where I worked had moved their staff leave system to something called "personal time-off," better known as PTO. In this system, staff are given a set number of days (I believe it was 32 days annually at my hospital) each year for leave, combining sick leave, vacation, mental-health days, birthday leave, and holidays into one bucket. When medical staff took leave, whether sick or vacation, it came from the same allotment.

What this did, and I regularly it saw it in action, was incentivize staff to come to work sick, because if they stayed home, the result was basically burning a vacation day. If medical provider A called in sick 8 days, and medical provider B called in three, then medical provider B got five more vacation days than medical provider A. You'd hope that providers would resist this temptation, but the lure was still there, thanks to administration's decision to adopt such a program, intended to decrease use of sick leave. In my opinion, this common administrative view, in medicine and elsewhere, reflects a fear that everyone is cheating the sick leave system, calling in sick when they aren't, and ineffectively strives to prevent such "cheating." And the unintended but obvious result: making patients sick by incentivizing medical staff to work when ill.

Hospitals, clinics, and other medical facilities need to look at their systems and policies and ask themselves these questions: Do we properly look for and screen sick providers? Do we have an adequate back-up coverage system in place, providing support to providers when they are ill? And do we have leave systems that incentivize our medical staff to come to work?

This seems so intuitive to me and makes me struggle to understand why any place that claims to exist to heal the sick would instead have systems that make patients, and in the end the public, sicker. And during this crazy COVID-19 era, the stakes could not be higher.

Legal Actions

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November 1, 2019 – January 31, 2020

Below are summaries of interim and final actions taken by the Washington Medical Commission (WMC) that were reported to the Federation of State Medical Boards between November 1, 2019 and January 31, 2020. Statements of Charges, Notices of Decision on Application (with exceptions), Modifications to Orders (with exceptions), 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 WMC website.

Practitioner Credential and County	Order Type	Date	Cause of Action	Commission Action
Summary Actions				
Shibley, Eric MD60108064 King	Ex Parte Order of Summary Action - Restriction	12/30/19	Alleged substandard recordkeeping and negligent chronic pain management.	Restriction – no prescribing controlled substances.
Interim and Formal Actions				
Edstrom, Kenneth MD00026074 Pierce	Agreed Order	01/16/20	Respondent made inappropriate comments during a physical exam and misrepresented information on a license application.	Boundaries coursework, chaperone when examining female patients, written research paper, personal appearances, $2,000 fine, and termination no sooner than two years.
Lamberton, Robert PA60256531 Okanogan	Final Order - Default	12/04/19	Moral turpitude and conviction of a felony.	Suspension for not less than ten years, and pre-conditions prior to request for reinstatement.
Lupton, Patricia PA60638457 Out of state	Final Order - Default	01/28/20	Failure to provide requested information during an investigation and failure to comply with a WMC order.	Indefinite suspension.
Neitlich, Jeffrey MD60237608 Whatcom	Final Order - Default	01/28/20	Failure to provide requested information during an investigation.	Indefinite suspension.

Roberts, Brenda MD00049464 Out of state	Agreed Order	01/16/20	Interim stipulated order suspending license entered by the Oregon Medical Board in July 2018 for substandard prescribing practices, self-prescribing, and misrepresentation.	Development of a re-entry work plan, supervisor reports, compliance with physician health program requirements, personal appearances, $1,000 fine, and termination no sooner than discharge by health program.
Washington, Sherman MD60404594 Out of state	Final Order - Default	01/28/20	Failure to provide requested information during an investigation.	Indefinite suspension.
Informal Actions				
Baker, David MD00025510 Whatcom	Informal Disposition	11/14/19	Alleged disruptive behavior.	Multidisciplinary evaluation and comply with recommendations, written research paper, personal reports, personal appearances, $3,000 cost recovery, and termination no sooner than completion of all requirements.
Borish, Stanley MD00015305 King	Informal Disposition	01/16/20	Alleged substandard recordkeeping and negligent chronic pain management.	Voluntary surrender
D'Jang, Douglas PA10003479 King	Informal Disposition	01/16/20	Alleged negligent chronic pain management, and failure to maintain a current practice arrangement plan.	Controlled substance prescribing and treating homeless patients coursework, written research paper, practice reviews, supervisor reports, personal appearances, $1,000 cost recovery, and termination no sooner than 18 months.
Eggertsen, Sam MD00016014 Snohomish	Informal Disposition	01/16/20	Alleged substandard recordkeeping and medication management.	Voluntary surrender at retirement.
Escobar, Susana MD00041997 Snohomish	Informal Disposition	11/14/19	Alleged boundary violations.	Boundaries coursework, written research paper, personal appearances, $1,000 cost recovery, and termination no sooner than 18 months.
Hosalkar, Harish MD60416132 Out of state	Informal Disposition	01/16/20	Order entered by the Medical Board of California in November 2018 for irregular research practices.	Compliance with the California order, notification if Respondent practices in WA, research restriction, $1,000 cost recovery, and termination no sooner than release by the California Board.

Kevwitch, Mansel MD00030853 Skagit	Informal Disposition	01/16/20	Alleged wrong site procedure.	Recordkeeping coursework, written research paper, peer group presentation, personal appearances, $1,000 cost recovery, and termination no sooner than two years.
Lent, Dolly MD60649476 Thurston	Informal Disposition	11/14/19	Alleged negligent medication management.	Medication management coursework, written research paper, ethics coursework, personal appearances, $1,000 cost recovery, and termination no sooner than six months.
Siegel, Michael MD00029244 Out of state	Informal Disposition	01/16/20	Oregon Medical Board order in October 2018 stating that Respondent retired his license while under investigation.	Voluntary surrender at retirement.
Slack, Donald MD00032809 Skagit	Informal Disposition	11/14/19	Alleged failure to fully review medical records and diagnose head injury.	Clinical coursework, written research paper, peer group presentation, personal appearances, $1,000 cost recovery, and termination no sooner than two years.

Stipulated Findings of Fact, Conclusions of Law, and Agreed Order: A settlement resolving a Statement of Charges, and containing an agreement by the licensee to comply with certain terms and conditions to protect the public.

Stipulated Findings of Fact, Conclusions of Law, and Final Order: **A**n order issued after a formal hearing before the Commission imposing certain terms and conditions to protect the public.

Stipulation to Informal Disposition (STID): A settlement resolving a Statement of Allegations., and containing an agreement by the licensee to comply with certain terms and conditions to address the Commission's concerns.

Ex Parte Order of Summary Action: An order summarily restricting or suspending a licensee's practice of medicine. The licensee has an opportunity to defend against the allegations supporting the summary action.

Commissioner Spotlight

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

Candace Vervair, Public Member

I am a retired paralegal from the Office of Attorney General (AG), and my time there was spent reviewing and helping with medical professional disciplinary cases. I learned so much from this experience, and understand the importance of determining whether a practitioner has the public well-being in mind with their actions. I decided to join the WMC to help keep the Washington public safer. Here is a little about me:

- I grew up in Spokane, Washington in the 50's and 60's, got married to a local guy and we lived there until 1990. We're hoping to move back there this year.
- In my day job at the AG's office, I started as a legal assistant and in time moved up to a paralegal. Our job was to help prepare cases that were being litigated regarding the licenses of health care professionals.
- I think the one thing PAs / MDs should do in their practice is be passionate about their work. You have really important jobs, and should enjoy them.
- My career has surprised me by how it has changed since graduating from college. I graduated with a Sociology degree from the UW in 1973. My first "career" was as a travel agent for about 20 years. Later, among other things, I worked as an assistant in the Nursing and Dental Hygiene departments at a community college. The last 18 years of my working life was in the legal profession.
- Technology has changed health care, from my perspective as a patient, by making it so much easier to record and access medical information.
- I see the future of medicine as changing rapidly, with technology getting more sophisticated.
- The profession could benefit from learning how to screen for colon cancer with some method other than a colonoscopy (from a patient's point of view). Once you turn 50, you'll understand.
- During my free time I love to walk, read, kayak and garden. I love being outside.
- The most memorable trip I ever took was back in the 80's, when my husband and I toured New Zealand by car and stopped in Fiji on our return.
- I want to explore and hike as many National Parks as I can. I was able to hike Volcanoes National Park during our recent trip to Hawaii.
- I absolutely cannot live without peanut butter. And chocolate.
- My fitness routine includes jumping on my elliptical for 30-40 minutes each morning and walking my dog 1-2 miles almost every day.
- One day I would like to master painting and drawing once again. I was pretty good at it in my younger days.
- Nobody would ever suspect that I am irrationally afraid of heights.
- Friends would describe me as calm, friendly and easy to be around. My husband may have a different take.
- I give back to my community by serving dinner once a month to the homeless at Union Gospel Mission with a group from my church. Taco Monday. We serve about 150-200 people each month.
- This is on my bucket list: walk a 10K in each state capitol for a Volkswalk award (my walking group – it's an international organization that hosts walks everywhere)
- An item I would never throw out – my mom's china. Too many good memories.
- I would like to meet the author CS Lewis.
- My first car was a 1970 AMC Gremlin. Paid for with cash that I earned working at Expo 74 in Spokane.
- I wish mom jeans of the 80's would come back into style
- My first concert was the Beatles in Seattle, on their second tour in America. I'm pretty sure my left ear never recovered from all the screaming during the concert.
- The one superpower I would like to have is to be able to fly.
- If I have learned one thing in life, it is that you always have a choice.

Members and Meetings

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

Medical Commission Members

Chair: Alden W. Roberts, MD
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Toni L. Borlas
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Robert H. Small, MD
Candace Vervair
Richard Wohns, MD
Yanling Yu, PhD

Update! Editorial Board

James E. Anderson, PA-C	Micah Matthews, MPA
Harry Harrison Jr., MD	Bruce Hopkins, MD
Candace Vervair	Jimi Bush, Managing Editor

Email us with your questions and comments.

2020 WMC Meeting Dates

Date	Location
April 9 - 10	~~Capital Event Center (ESD 113)~~ Canceled 6005 Tyee Drive SW Tumwater, WA 98512
May 14 - 15	Capital Event Center (ESD 113) 6005 Tyee Drive SW Tumwater, WA 98512
July 9 - 10	Capital Event Center (ESD 113) 6005 Tyee Drive SW Tumwater, WA 98512
August 20 - 21	Capital Event Center (ESD 113) 6005 Tyee Drive SW Tumwater, WA 98512
October 1 - 3	TBD
November 12 - 13	Capital Event Center (ESD 113) 6005 Tyee Drive SW Tumwater, WA 98512

All upcoming meeting and workshops have been either canceled or been converted into a teleconference. Check our website for specific event details.

Policy meetings usually take place on the Thursday of the commission meeting at 4:00 pm.

Business meetings usually take place on the Friday of the commission meeting at 8:00 am.

Policy, business meetings and lunch time presentations are open to the public. Sign up to have the agenda emailed to you as it becomes available.