



UPDATE!

Washington Medical Commission Vol. 9, Summer 2019

Message From The Chair: Patient Safety and Medical Error

Alden Roberts, MD, MMM, FACS

The mission of the Washington Medical Commission (WMC) is “promoting patient safety and enhancing the integrity of the profession through licensing, discipline, rule making, and education.” All actions taken by WMC are intended to promote patient safety and the integrity of the profession. No matter how skilled the clinician, given the complexity of our environments, preventable adverse events happen. Adverse outcomes don’t normally occur because of incompetence or a lack of knowledge.

There are a lot of ways to look at error. There are errors of omission and errors of commission. Errors of omission are failing to do something that needs to be done. An example would be writing a note that a follow-up CT scan needs to be ordered to rule out cancer, but then forgetting to write the order. Errors of commission would be doing something that shouldn’t have been done, such as giving a patient an antibiotic to which they are allergic. There are also cognitive

errors, such as making the wrong diagnosis or misidentifying a structure at surgery.

There are 4 major sources of error that operate in a dependent fashion:

- Human factors and cognitive errors;
- System problems;
- Cultural problems;
- Unnecessary variation (which is actually both a system problem and a cultural problem).

Human Factors and Cognitive Errors

Physicians operate in complex situations with major time constraints. There are a myriad of normal human reactions that serve us well in most circumstances, but contribute to error in others. In an emergency, our field of vision tends to narrow and alternatives diminish. That is helpful when quick action is necessary, but if our normal course of action

We function in an extremely complex environment and bad things will happen that are preventable, no matter how good the clinician.

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WMC Mission

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

Message From the Chair

doesn't work, our tendency is to not see alternatives which might be lifesaving. An example of this would be to persist in trying to intubate when a glide scope or cryothyroidotomy is required. Another factor is the compression of time in an emergency; we often misjudge how long we have taken to do something in situations when time is critical. A third human factor is that we see what we expect to see. Unfortunately, that may lead us to cut the common bile duct because we saw it as the cystic duct. A fourth human factor is cognitive dissonance, in which we persist in believing that we are correct in the face of overwhelming evidence to the contrary. This is actually one of the most common problems resulting in medical error, and it is one that all of us are subject to from time to time. Human factor issues, including cognitive errors, are universal and not unique to medicine.

and change the system so no one will make that error again, hopefully. We have to change the culture, so everyone feels safety is his or her responsibility, and identifies hazards before someone gets hurt." One of the interesting things in Dr. Leape's statement is that there is no reference to harm. Is the misadventure that produces no actual harm, but could have, any different from the exact same action that did produce patient harm?

Cultural Problems

Cultural problems include work-arounds, where everyone does it to get through the day, but safety precautions are bypassed. Cultural problems include a culture of blame, which leads to pushing error underground, and to developing complex explanations of bad outcomes rather than examining those outcomes for improvement opportunities. A culture of

There are Three Types of Cognitive Error:

1. Errors of anchoring, where we fixate on early data, which subsequently skews our thinking.
2. Errors produce by recent case bias. We remember recent cases, especially if they were dramatic, which may influence or bias our thinking regarding future cases.
3. Errors produced by preconceptions or stereotypes. We make judgment based on preconceptions or stereotypes and may overlook data.

Human factor errors can be minimized by teams, by the leveling of hierarchy so that anyone can speak up or stop things, and by developing systems that prevent these errors from reaching the patient. **Human factors cannot be fixed by education or trying harder.**

System Errors

Every system is designed to achieve exactly the results that it gets, including the errors that occur. An example of a system error would be the presence of an unlabeled liquid or syringe on an operating table. That liquid or syringe will, sooner or later, be used in the wrong place. Allowing unlabeled material to be on the operating table is a flawed system. To quote Dr. Lucian Leape, Adjunct Professor of Health Policy, at the Harvard School of Public Health and a Co-Founder of the National Patient Safety Foundation, "We need to quit blaming and punishing people when they make mistakes and recognize that errors are symptoms of a system that's not working right, and go figure out

tolerating disruptive clinicians results in the disruption of team performance, produces fear that delays the management of problems and may lead to the bypassing of safety measures. The medical profession must make a cultural change that moves from shame and blame induced secrecy to a "just culture." Just culture is described in Washington Medical Commission Guideline MD2015-08 titled "[A Collaborative Approach to Reducing Medical Error and Enhancing Patient Safety.](#)"

Just culture is an approach to reducing error in high-risk, complex industries by recognizing that errors are often the result of flawed systems. Blaming individuals for human error does not make systems safer. A just culture describes an environment where professionals believe they will be treated fairly and that adverse events will be treated as opportunities for learning. A just culture encourages open communication so that near misses can serve as learning tools to prevent

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future problems, and adverse events can be used to identify and correct root causes. It holds individuals accountable for the quality of their choices and for reporting errors and system vulnerabilities. It holds organizations accountable for the systems they design and how they respond to staff behaviors. In that guideline, The WMC commits to endorsing just culture principles. The WMC encourages institutions, hospitals, clinics and the health care system to adopt a just culture model to reduce medical error and make systems safer. Likewise, the WMC will use just culture principles in reviewing cases of medical error. This is a step towards accountability and away from punishment. In a just culture, physicians and physician assistants accept responsibility for the problem, bring the issue to the attention of others involved, and look to see how to prevent others from making the same mistake in the future. Does the WMC take this into consideration when evaluating a complaint? Yes, we do.

Unnecessary Variation

Unnecessary Variation: To quote Edward Deming, “Uncontrolled variation is the enemy of quality.” It is disruptive to teams, as when team members change, what is expected will also change. There is evidence that following protocols in the ICU results in better outcomes than not following those protocols. There is good evidence that if two processes are relatively equal in their outcomes, results are better if one process is chosen rather than allowing uncontrolled variation. UTI bundles have clearly reduced the incidence of urinary tract infections. However, standardization needs to be cautiously and appropriately developed and outcomes measured to determine the efficacy of standardization. In order to effectively control variation, analytics are required to understand what variation is significant and what is not.

Reduction of medical error, and to a significant degree the reduction of bad outcomes in general, requires that we not be afraid to look at outcomes. In this regard, our profession has been seriously lacking. Most importantly, we need to investigate and develop effective, multidisciplinary peer review. There are organizations in this state that do peer review extremely well, but most do not. It requires data, teamwork, and analytics. It requires participation by physicians who are already too busy.

To improve patient safety requires incorporating the principles of safety developed in other complex industries and it needs to be physician driven. Medical organizations, led by physicians, need to acquire the attributes of a highly reliable organization, including a preoccupation with failure, a reluctance to accept simple explanations for problems, a deference to expertise regardless of titles or experience, a sensitivity to operations (i.e. how things are working) and resilience (preparation in how to respond to failures and continually find new solutions, refine the ability to improvise, or quickly develop new ways to respond to unexpected events).

The WMC supports the Communication and Resolution Program promoted by the Washington Patient Safety Coalition and have agreed to consider their findings when assessing cases for disciplinary action. In addition WMC will take into consideration effective peer review, and may find that we have nothing more to add in our role of protecting the public. Patient safety is our most important responsibility. The greatest improvements will come through local measures and physician

involvement. WMC supports these efforts.

Thank you for your attention,

Alden Roberts,
MD, MMM, FACS



Upcoming Buprenorphine Waiver Trainings as of June 20, 2019 (No cost)

Chemical Dependency Professionals are welcome to attend upcoming, no cost trainings to learn more about the use of buprenorphine for treatment of opioid use disorder. If you have any questions, please contact the [program director](#).

Completion of the 4-hour in-person course as well as a 4-hour online follow-up allows physicians to apply for the waiver to prescribe buprenorphine for office-based treatment of opioid use disorder.

[Learn more](#) about dates and locations.

Sexual Misconduct: Myth vs. Fact



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Melanie de Leon, JD, MPA Executive Director

A touch, a word or a look can be reassuring to a patient, but it can also be interpreted as sexual assault or misconduct in today's environment. What may have been okay 30 years ago is no longer appropriate and it is up to you to learn the difference. Here are some hard and fast rules that you should incorporate into your practice if you haven't already done so:

- Never help a patient disrobe – there is no appropriate way to interpret that. If you want a patient to change into a robe, you need to leave the room and give them privacy. If the patient is a minor and needs assistance, have the parent help.
- Never pat a patient on the buttocks or in that general region.
- Never touch their hair, smell their hair or comment about their appearance unless it is pertinent to the examination, diagnosis and/or treatment plan.
- Stating a clinical observation is generally ok; relating that observation to their dating or sex life is not.
- Don't talk about their sex life, your sex life, anyone's sex life, unless it is pertinent to the examination, diagnosis and/ or treatment plan.
- Entering into a dating or sexual relationship consensually, or in exchange for services (such as prescriptions) is never allowed. Regardless whether or not they are a current patient, there will always be a power imbalance.
- Many acts performed by practitioners, when non-consensual or when the patient is unable to consent, legally constitute sexual assault and could result in criminal conviction.

Common misconceptions about sexual misconduct may lead you down a path you don't want to go. It behooves you to know the boundaries. Here are some examples from Washington and other jurisdictions:

1. **MYTH:** It is okay so long as there is no power imbalance. Some argue that a sexual relationship between practitioner and patient is not abusive when it is consensual.
FACT: Expert evidence in a Texas case against a practitioner stated that a practitioner *always* has inherent power over a patient. Patients come to practitioners with a health condition or a need and are relying on the judgment and expertise of the practitioner.
2. **MYTH:** It's okay because no one can prove anything.
FACT: Most sexual misconduct happens between two

people, without outside witnesses, but that does not mean the misconduct cannot be proven. In a case from Canada, a client made a bizarre sounding allegation that the practitioner had put his penis on her forehead as she lay on the treatment table. No one else was present in the office. The practitioner denied the allegation and suggested the patient had misinterpreted his shirt tail as his penis. The Canadian Discipline Committee found the patient credible, not the practitioner. A significant reason they found the practitioner not credible was forensic evidence. He had rewritten part of his chart in an attempt to create doubt about the client's story and to establish that the client was a chronic liar.

3. **MYTH:** It's okay because no one is going to tell. Where a sexual relationship is consensual and is conducted privately, a practitioner may believe that no one will find out.

FACT: Time passes, circumstances change and there is no statute of limitations on unprofessional conduct. In a Washington case, a practitioner and a patient began a sexual relationship while the patient was still being treated by the practitioner. They married. Years passed. No one knew that their sexual relationship had begun during the course of their earlier professional relationship. Then the marriage failed and the patient/spouse filed a complaint. While one can question the motivation for making the complaint then, the practitioner was found to have engaged in unprofessional conduct and was disciplined by the Medical Commission.

It's great to be a concerned practitioner, but when that concern is misconstrued by a patient, or goes beyond legitimate concern, it may lead to an accusation of sexual misconduct, or worse, actual sexual abuse or assault. Be alert and be safe.

Need a Speaker?

The Medical Commission will come to you to speak on a variety of topics.

[Learn More](#) and request a speaker.



Rulemaking Efforts



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Amelia Boyd
Program Manager

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 Medical Commission adopt rules for both allopathic physicians and physician assistants. On May 17, 2019 the Medical Commission approved the initiation of rulemaking. A stakeholder workshop will be held on July 10, 2019.

For more information about these rules, please visit our [website](#).

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 Medical Commission 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 commission 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.

For more information on this rule, please visit our [rulemaking site](#).

Center for Disease Control and Prevention (CDC) Issues Key Clarification on Guideline for Prescribing Opioids for Chronic Pain.

"The Guideline is not intended to deny any patients who suffer with chronic pain from opioid therapy as an option for pain management. Rather, the Guideline is intended to ensure that clinicians and patients consider all safe and effective treatment options for patients. Clinical decision-making should be based on the relationship between the clinician and patient, with an understanding of the patient's clinical situation, functioning, and life context, as well as a careful consideration of the benefits and risk of all treatment options, including opioid therapy. CDC encourages physicians to continue to use their clinical judgment and base treatment on what they know about their patients, including the use of opioids if determined to be the best course of treatment. Providers should communicate frequently with their patients to discuss both the benefits and risks of opioid therapy and revisit treatment plans for pain regularly to achieve the most positive outcomes for patients."

Read the full letter from the CDC [here](#).
Read the press release from the American Society of Hematology [here](#).

Aims of CDC Guidelines for Prescribing Opioids for Chronic Pain

- Improve provider-patient communication about risks/benefits of opioid therapy for chronic pain
- Improve the safety/effectiveness of pain treatment
- Reduce risks associated with long-term opioid therapy, including OUD and overdose
- Intended for primary care physicians
- Not intended for patients receiving active cancer treatment, palliative care, or end-of-life care
- Not intended to dictate Standard of Care
- <https://www.cdc.gov/drugoverdose/prescribing/guideline.html>



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PA News: Protect Your Skin and Practice



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Theresa Schimmels, PA-C Physician Assistant Member

It's summertime! When the sun comes out and the weather warms up, the people of the Northwest flock outside to the beaches of lakes, rivers, and ocean. We also head up to the hills to hike, bike, and camp and to the parks to play with our children, dogs, and picnic with friends and family. Break out the sunscreen!

1 in 5 Americans will develop skin cancer by the age of 70, a statistic posted by the Skin Cancer Foundation. Washington is among the top 12 states for skin cancer with approximately 4,000 residents diagnosed with skin melanoma in 2014. Jefferson, Island, King, San Juan, Kitsap, Skagit and Snohomish counties had the highest rates in the state. It is thought that the Puget Sound area has higher rates based off the fact that skies are often overcast with cooler temperatures, leading people to think they do not need sunscreen. According to the CDC, "80% of the sun's UV rays can pass through clouds and can reflect off surfaces like water, sand, or snow, increasing exposure to UV radiation".

So, what does this have to do with the Medical Commission? We often see cases where providers from primary care and dermatology remove lesions from the skin, either by punch or shave biopsy, and then throw away the tissue. This can be acceptable in the case of

an obvious seborrheic keratosis, skin tag, or sebaceous cyst, if there is precise documentation as to the site, size, and description of the lesion. The risk is that the lesion is more than what it appears, like an amelanotic melanoma, Merkel Cell Carcinoma, pigmented basal cell carcinoma, or sebaceous carcinoma. When you miss the diagnosis because you tossed the sample/specimen, you may potentially cause harm to the patient.



The jury is out and there are many opinions in the Dermatology community as to whether you should send every biopsy out for pathology processing. To be honest, there is no right or wrong answer. I personally send anything that isn't a skin tag out for pathology as do the physicians that I have worked with in my 16 year dermatology career.

The bottom line: document, document, document. Take a photo and put it in the chart for future reference. Make sure you discuss and document the ramifications of not sending a biopsy out for pathology with the patient as part of your informed consent. And make sure you have an appropriate follow up plan with the patient if the lesion does not resolve or recurs.

And don't forget to wear your sunscreen and advise your patients to wear theirs! SPF 30 should do the trick, all year round here in Washington! Happy Summer!

Health Care's Role in Achieving Social Change



The Medical Commission hosts an educational conference every year in place of a regular meeting. The conference is free and open to the public. We encourage all who are interested to attend.

This year we are pleased to host subject matter experts discussing Health Care's Role in Achieving Social Change.

Visit our [web page](#) for more information and [register now](#).

When: October 4-5, 2019

Where: The Hilton at Sea-Tac

Cost: Free

Legal Actions



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February 1, 2019 – April 30, 2019

Below are summaries of interim and final actions taken by the Medical Commission. 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 Medical Commission [website](#).

Practitioner Credential and County	Order Type	Date	Cause of Action	Commission Action
Summary Actions				
Holland, Robert MD00037746 Pierce	Ex Parte Order of Summary Action - Restriction	03/28/19	Alleged felony-equivalent conviction for a sex-related offense with a minor, and sexual misconduct.	Restriction – no direct patient contact.
Roberts, Brenda MD00049464 Out of state	Ex Parte Order of Summary Action - Suspension	03/27/19	Alleged interim suspension of license to practice medicine by the OR Medical Board in July 2018.	Suspension.
Interim and Formal Actions				
Caveny, Scott MD60494583 Spokane	Final Order - Waiver	04/11/19	Respondent is unable to practice with reasonable skill and safety due to a health condition.	Indefinite suspension.
Freeman, Melissa MD60459880 Clark	Final Order	03/08/18	Respondent is unable to practice with reasonable skill and safety due to a health condition.	Indefinite suspension.
Knapp, David MD00015769 Out of state	Final Order - Default	04/11/19	Respondent's license to practice medicine was suspended by the Medical Board of CA in April 2017.	Indefinite suspension.
Rosnow, Jan MD60211102 Out of state	Agreed Order	04/11/19	Respondent is unable to practice with reasonable skill and safety due to a health condition.	Voluntary surrender of license.
Sung, Charles MD00036139 Benton	Agreed Order	03/07/19	Disruptive behavior creating a risk of harm to patients, and allowing employees to assist with procedures for which they were not properly credentialed.	Professional boundaries coursework, psychotherapy, professional coaching, written policies, staff assessments, personal appearances, \$8,000 fine, and termination no sooner than 5 years.
Informal Actions				
Ashori, Mohammad MD60556419 Pierce	Informal Disposition	03/07/19	Alleged reprimand and 30-day suspension of license by the Oregon Medical Board in July 2018 for treating a co-worker without following standard procedures.	Ethics coursework, written research paper, personal appearances, \$100 cost recovery, and termination no sooner than completing requirements, including at least one personal appearance.

Legal Actions



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Practitioner Credential and County	Order Type	Date	Cause of Action	Commission Action
Godbout, Christopher MD60281938 King	Informal Disposition	04/11/19	Alleged inadequate evaluation and management of a chronic pain patient.	Opioid prescribing coursework, written research paper, practice reviews, compliance with pain management rules, utilization of PMP, personal appearances, \$2,000 cost recovery, and termination no sooner than 3 years.
Guo, Jinfeng MD00038303 Snohomish	Informal Disposition	04/11/19	Alleged negligent failure to perform indicated evaluations in an emergent situation.	Clinical coursework, written research paper, personal appearances, \$1,000 cost recovery, and termination no sooner than 1 year.
Knox, David MD00018242 Out of state	Informal Disposition	04/11/19	Alleged practice of authorizing the medical use of marijuana at a location other than a practice's permanent location.	Medical use of marijuana coursework, ethics coursework, written research paper, personal appearances, \$1,000 cost recovery, and termination no sooner than 1 year.
Knox, Rachel MD60572278 Out of state	Informal Disposition	04/11/19	Alleged practice of authorizing the medical use of marijuana at a location other than a practice's permanent location.	Medical use of marijuana coursework, ethics coursework, written research paper, personal appearances, \$1,000 cost recovery, and termination no sooner than 1 year.
Kontogianis, Christopher MD00019338 Benton	Informal Disposition	04/11/19	Alleged negligent failure to inform patient of treatment options and perform surgery to reduce a severe fracture.	Clinical coursework, written research paper, peer group presentation, personal appearances, \$1,000 cost recovery, and termination no sooner than 1 year.
Munir, Sayf MD60322694 Spokane	Informal Disposition	03/07/19	Alleged risk of harm if Respondent renews license and resumes treating patients.	No license renewal without prior health evaluation and Commission approval.
Pearce, Patrick MD00019290 Spokane	Informal Disposition	04/11/19	Alleged negligent prescribing, negligent recordkeeping, boundary violations, and sexual misconduct.	Opioid prescribing coursework, recordkeeping coursework, ethics coursework, written research paper, psych evaluation, compliance with pain management rules, utilization of PMP, personal appearances, \$3,000 cost recovery, and termination no sooner than 3 years.
Piper, August MD00012652 King	Informal Disposition	03/07/19	Alleged negligent recordkeeping.	Recordkeeping coursework, written research paper, personal appearances, practice reviews, \$1,000 cost recovery, and termination no sooner than 1 year.

Legal Actions



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Practitioner Credentialed and County	Order Type	Date	Cause of Action	Commission Action
Reichel, Jennifer MD00042289 King	Informal Disposition	04/11/19	Alleged negligent prescribing of a legend drug to a patient and to oneself.	Prescribing coursework, ethics coursework, written research paper, personal appearances, \$1,000 cost recovery, and termination no sooner than 1 year.
Rotchford, James MD00019338 Jefferson	Informal Disposition	04/11/19	Alleged negligent recordkeeping.	Psychiatric diagnosis and treatment coursework, written research papers, practice reviews, utilization of PMP, personal appearances, \$200 cost recovery, and termination no sooner than 2 years.
Skidmore, Allen MD00046129 Spokane	Informal Disposition	03/07/19	Alleged negligent chronic pain management.	Prescribing coursework, written research paper, utilization of PMP, personal appearances, \$1,000 cost recovery, and termination no sooner than 2 years.
Smith, Ray MD60648525 Snohomish	Informal Disposition	04/11/19	Alleged negligent recordkeeping and prescribing.	Prescribing coursework, recordkeeping coursework, written research papers, peer group presentation, personal appearances, \$1,000 cost recovery, and termination no sooner than 2 years.
Sorensen, Ronald MD00038461 Out of state	Informal Disposition	04/11/19	Alleged restriction of license to practice medicine by the College of Physicians and Surgeons of Ontario, Canada, in November 2017.	Comply with the Ontario Order and termination no sooner than termination by the College of Physicians and Surgeons of Ontario.
Zadina, Simon MD60116602 Thurston	Informal Disposition	03/07/19	Alleged negligent recordkeeping.	Recordkeeping coursework, written research paper, written office protocol, practice reviews, personal appearances, \$1,000 cost recovery, and termination no sooner than 1 year.

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: An 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.

Members and Meetings



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Mimi Winslow, JD

Yanling Yu, PhD

Meetings and Events

Medical Commission Meeting

July 11-12 6005 Tye Drive SW
Tumwater, WA 98512

Lunch Presentation: Communication and Resolution Programs¹

Bruce Cullen, MD
Liz Leedom, JD

July 11 6005 Tye Drive SW
12:30 - 1:30 Tumwater, WA 98512

Medical Commission Meeting

August 22-23 6005 Tye Drive SW
Tumwater, WA 98512

Lunch Presentation: Practitioner Competence

David Bazzo, MD
Patricia Smith, MPH

August 22 6005 Tye Drive SW
12:30-1:30 Tumwater, WA 98512

Medical Commission Educational Conference

October 4-5 Hilton Seattle Airport
17620 International Blvd
Seattle, WA 98188

Medical Commission Meeting

November 14-15 6005 Tye Drive SW
Tumwater, WA 98512

Lunch Presentation:

A Brief and Colorful History of the WMC
Mike Farrell, JD

November 14 6005 Tye Drive SW
Tumwater, WA 98512

All meetings and events are subject to change.

Only certain events are open to the public during the Medical Commission Meetings. [Sign-up](#) to have the agenda emailed to you as it becomes available.

*¹ This activity has been approved for
AMA PRA Category 1 Credit™*

Update! Editorial Board

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[Email us](#) with your questions and comments.